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BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:	Case No. D1-93-29927
JOSEPH J. VERBRUGGE, M.D. 6390 Locust Way Englewood, CO 80111	OAH No. N9602069
Physician's and Surgeon's Certificate No. C-34826,	
Respondent.	

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Medical Board of California as its Decision in the above-entitled matter.

This Decision shall become effective on April 27, 1998.

IT IS SO ORDERED March 27, 1998.

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:	Case No. D1-93-29927
JOSEPH J. VERBRUGGE, M.D. 6390 Locust Way Englewood, CO 80111	OAH No. N9602069
Physician's and Surgeon's Certificate No. C-34826,	
Respondent.	

PROPOSED DECISION

This matter came on regularly for hearing before Jaime René Román, Administrative Law Judge, Medical Quality Hearing Panel, Office of Administrative Hearings, in Sacramento, California, on February 5, 1998.

Complainant was represented by Fred A. Slimp II, Deputy Attorney General, Health Quality Enforcement Section, Department of Justice.

Respondent Joseph J. Verbrugge, M.D. ("Respondent"), appeared and was represented by Parker, Milliken, Clark, O'Hara & Samuelian, Attorneys at Law, by Frank Albino, Esq.

Evidence was received and following argument the matter deemed submitted on February 5, 1998.

FINDINGS OF FACT

Procedural Findings

I

On November 27, 1995, Ronald Joseph made and filed the Accusation in his official capacity as Executive Director of the Medical Board of California (hereinafter "Board"), Department of Consumer Affairs, State of California.

II

On December 11, 1995, Respondent filed a Notice of Defense.

III

On February 21, 1996, the matter was set and noticed for a hearing to commence on April 8, 1996.

IV

On March 8, 1996, Respondent submitted a request for continuance of the hearing set on April 8, 1996. On March 12, 1996, Respondent's counsel, Isaacson, Rosenbaum, Woods & Levy, Attorneys at Law, by Gary Lozow, Esq.,[1] also submitted a request for continuance of the hearing. Respondent having agreed to refrain from the practice of medicine, pending hearing in this matter, and there being no objection by Complainant's counsel, Jana Tuton, Supervising Deputy Attorney General, the matter was continued by Presiding Administrative Law Judge Stephen J. Smith, and subsequently noticed for hearing to commence on October 7, 1996.

V

On August 20, 1996, Respondent filed a request for continuance, reiterating a willingness to refrain from practicing medicine in California pending hearing. The request, referred to Presiding Administrative Law Judge Stephen J. Smith, and there being no objection by Complainant's counsel, Gail M. Heppell, Deputy Attorney General, as a result of Respondent's refraining from the practice of medicine in California, was granted and subsequently noticed for hearing to commence on January 6, 1997.

VI

On November 27, 1996, Ronald Joseph made and filed the First Amended Accusation in capacity as set forth in Finding No. I.

VII

On December 16, 1996, Respondent, by and through his counsel, Robert B. Zaro, Esq., and Nossaman, Guthner, Knox & Elliott, Attorneys at Law, by Robert J. Sullivan, Esq., moved for a continuance of the hearing. Complainant's counsel, Fred A. Slimp II, Deputy Attorney General, opposed the motion. The motion, referred to Presiding Administrative Law Judge Stephen J. Smith, was denied.

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[1] The firm is licensed to practice law in Colorado.

VIII

On January 4, 1997, Complainant's counsel, Fred A. Slimp II, summoned for jury duty, moved for a continuance of the hearing. There being no objection and good cause having been shown, the motion was granted by Presiding Administrative Law Judge Stephen J. Smith and the matter subsequently set for hearing to commence on August 4, 1997.

IX

On July 11, 1997, Complainant's counsel provided to the Office of Administrative Hearings various correspondence between counsel relating to a continued pending criminal matter in Colorado and a continued stipulation by and between counsel in which Respondent agreed to "non-practice" in California, the import of such submission was to solicit from Presiding Administrative Law Judge Stephen J. Smith a continuance of the August 4, 1997 hearing. The matter was assigned to Administrative Law Judge Jaime René Román, Medical Quality Hearing Panel, for consideration. Lacking good cause, the motion for continuance was denied on July 11, 1997, and Respondent prohibited, pending hearing, from undertaking any activities in the State of California for which a license by the Medical Board of California is required.

X

On July 17, 1997, Respondent, by and through his counsel, Isaacson, Rosenbaum, Woods & Levy, Attorneys at Law, by Richard K. Kornfeld, Esq., moved Presiding Administrative Law Judge Stephen J. Smith for reconsideration of the Order on July 11, 1997, and, thereby, for a continuance of the August 4, 1997 hearing. There being no opposition by Complainant's counsel, Fred A. Slimp II, the July 11, 1997 order was vacated and dismissed, the August 4, 1997 hearing continued to and noticed for November 3, 1997.

XI

On September 5, 1997, Respondent's counsel, Isaacson, Rosenbaum, Woods & Levy, Attorneys at Law, withdrew as counsel for Respondent.

XII

On November 3, 1997, the matter, continued, was noticed for hearing to commence on November 12, 1997.[2]

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[2] The record is unclear as to the reasons for the continuance.

XIII

On November 6, 1997, the matter, continued, was noticed for hearing to commence on November 26, 1997.[3]

XIV

On November 10, 1997, the matter, continued, was noticed for hearing to commence on February 5, 1998.[4]

XV

On January 7, 1998, Respondent, by and through his counsel, Parker, Milliken, Clark, O'Hara & Samuelian, Attorneys at Law, by Frank Albino, Esq., moved, inter alia, for a continuance of the hearing set to commence on February 5, 1998. Opposed by Complainant's counsel, Fred A. Slimp II, the motion was denied by Presiding Administrative Law Judge Stephen J. Smith on January 20, 1998.

XVI

On February 2, 1973, the Board issued Physician and Surgeon's Certificate No. C-34826 to Respondent.

A. On July 25, 1994, Respondent's certificate was revoked, stayed, and placed on five years probation with terms and conditions.

B. Respondent's certificate has been in a Delinquent Status since January 31, 1996, for nonpayment of renewal fees.

Factual Findings

XVII

On July 10, 1973, Respondent was licensed to practice medicine in Colorado and issued License No. 18269.

XVIII

On December 16, 1994, in a matter entitled In the Matter of the Disciplinary Proceeding Regarding the License to Practice Medicine in the State of Colorado of Joseph J. Verbrugge, Jr., M.D., License No. 18269, Case No. ME 93-06, Respondent's license to

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[3] See footnote 2.

[4] See footnote 2.

practice medicine in Colorado was revoked by the State Board of Medical Examiners, State of Colorado.

XIX

The facts and circumstances underlying the discipline set forth in Finding No. XVIII are as follows:

A. Respondent, specialized in the practice of anesthesiology, had a physician-patient relationship with R.L., an eight year old boy.

B. On July 8, 1993, R.L. underwent a right tympanoplasty and mastoidectomy at St. Joseph Hospital, Denver, Colorado. Respondent was in charge of providing and monitoring the anesthesia to R.L.

C. During the course of the surgery, R.L. suffered respiratory insufficiency, hypercarbia, severe metabolic disturbances, hyperthermia, and, ultimately, cardiopulmonary arrest resulting in the boy's death.

D. During the course of the surgical procedure, Respondent improperly failed to:

1. Employ a stethoscope to check R.L.'s breath sounds after intubation.

2. Calibrate the anesthesia machine's oxygen analyzer.

3. Adequately monitor the patient, including but not limited to:

a. Failing to employ any form of stethoscope to monitor R.L.'s breath sounds during anesthesia.

b. Failing to employ a temperature probe to monitor R.L.'s body temperature.

c. Closely observe and accurately record R.L.'s end-tidal carbon dioxide levels.

d. Closely observe and accurately record R.L.'s cardiac activity.

e. Ensure R.L.'s endotracheal tube remained properly positioned after an inadvertent airway disconnect.

4. Adequately respond to evidence of R.L.'s developing respiratory distress including, but not limited to:

   a. An accelerated respiratory rate.

   b. An accelerated heart rate.

   c. Evidence of irregularities in R.L.'s heart beat.

5. Appropriately conduct cardiopulmonary resuscitation including, but not limited to:

   a. Failing to take immediate steps to ascertain the adequacy of R.L.'s airway and breathing, and to re-establish R.L.'s circulation.

   b. Failing to produce a stethoscope to facilitate diagnosis of R.L.'s respiratory distress when requested by another physician.

   c. Prematurely ceasing his efforts at chest compression.

   d. Failing to demonstrate adequate knowledge of the proper sequence, choice, and dosage of resuscitative drugs.

6. Remain alert and vigilant during the entire course of R.L.'s anesthesia and surgery.

E. Respondent made numerous incorrect or incomplete essential entries upon R.L.'s anesthesia record including, but not limited to:

1. A notation that he heard bilateral breath sounds after intubation, when in fact he did not listen to R.L.'s breath sounds.

2. No notation of the type or amounts of anesthetic administered before and during the surgery.

3. No notation of the quantities of oxygen being administered before and during the surgery.

4. No notation of the fluids administered during surgery.

5. Incorrect and incomplete recording of R.L.'s pulse, blood pressure, and end-tidal carbon dioxide levels.

XX

On October 22, 1996, in the District Court, Denver County, State of Colorado, in a matter entitled People of the State of Colorado vs. Joseph J. Verbrugge, Case No. 95CR2256, Respondent was convicted, following trial, of violating Colorado Revised Statutes §12-36-117, to wit, Criminal Medical Negligence, for the conduct referenced in Finding No. XIX and a crime substantially related to the qualifications, functions, or duties of a physician and surgeon.

XXI

Respondent, on December 29, 1997, was sentenced by the District Court set forth in Finding No. XX to 12 months in the county jail, suspended for 12 months, probation with terms and conditions including that he perform 200 hours of community service, and not practice medicine in any capacity. The court granted Respondent a stay of execution on the sentence pending appeal.

XXII

Respondent, testifying and displaying remorse for his errant conduct as set forth in Finding No. XIX, provides no competent or dispositive explanation for his lapse of judgment in the treatment and care of R.L. Acutely aware of his conduct and unable to competently function, he terminated practice minutes after the death of this child.

Costs Findings

XXIII

The reasonable costs and fees paid and incurred by the Board in the investigation and enforcement of this matter (see also Finding Nos. I - XV) are $8,452.00.

Circumstances in Mitigation

XXIV

Respondent, presently engaged in the practice of real estate in Colorado, had, while licensed as a physician in Colorado, devoted himself to community activities relating to high school football and other sport activities, including service as a U.S. Swimming official, by providing pro bono care and treatment to young athletes.

XXV

Respondent, fully acknowledging his errant conduct as set forth in Finding Nos. XVIII - XX, seeks to maintain licensure to make amends for his misconduct. Licensed in three States (California, Colorado, and Wyoming[5]) and despite possessing any prior history of discipline until the incident on July 8, 1993, he lacks any desire to return to operating rooms.

XXVI

Respondent, with the sole exception of having failed to remit payments relative to his licensure (Finding No. XVI.A), has complied with the terms and conditions of the probation referenced in Finding No. XVI.B.

A. He undertook a psychological evaluation with no further referral.

B. He successfully took and passed an oral clinical examination.

XXVII

The discipline set forth in Finding No. XVI.B, arising from a Stipulation in Settlement; Decision and Order (In the Matter of the Accusation Against: Joseph J. Verbrugge, M.D., Case No. D-5650), resulted from an interim proceeding in Colorado (cf. Government Code §11529) for Respondent's conduct on July 8, 1993 (Finding No. XIX).

XXVIII

Respondent possesses a reputation, despite the discipline and conduct referenced in Finding Nos. XVIII - XX, as honest, competent, dedicated, and caring among professional peers.

Circumstances in Aggravation

XXIX

Respondent, since the incident on July 8, 1993 (Finding No. XIX), has not practiced medicine.

XXX

[5] Respondent's Wyoming license expired without the imposition of discipline.

Respondent's conduct as referenced in Finding No. XIX resulted in the death of a patient.

XXXI

Respondent is currently serving a term of probation (Finding No. XVI.B).

XXXII

Respondent's conduct as referenced in Finding No. XIX.E involved acts of moral turpitude substantially related to the qualifications, functions, or duties of a Board licensee.

XXXIII

Respondent's conduct as referenced in Finding No. XIX.D involved multiple acts of gross negligence.

XXXIV

Respondent is not fully rehabilitated.

DETERMINATION OF ISSUES

I

Respondent, on January 21, 1998, submitted a Motion to Dismiss with supporting declarations and points and authorities and, thereafter, a supplemental submission which included partial references to a reporter's transcript. Complainant objected to the timeliness of the motion. This tribunal, prior to the commencement of the hearing, ruled that the motion would be argued and submitted following the presentation of evidence herein.

Overruling Complainant's objection to the timeliness of Respondent's motion to dismiss (Title 1, California Code of Regulations, §1022(f)), the motion argues that the discipline of Respondent which forms the basis for the First Amended Accusation's allegations of violations by Respondent of Business and Professions Code §§141, 2234 and 2305 for out of state discipline must be dismissed because he has already been disciplined for the same conduct (Finding No. XIX) as referenced in Finding Nos. XVI.B and XXVII. Respondent's argument is compelling.

Complainant, in contrast, responds that while the underlying conduct (Finding No. XIX) is the same in each instance, the statutory import is sufficiently dissimilar. Indeed, Colorado, not unlike California, initiated disciplinary action against Respondent by the initiation of an interim suspension action ala Government Code §11529 (Finding No. XXVII) which formed the basis

for Respondent's earlier discipline (Finding No. XVI.B). The affect of such action did not bar Colorado from proceeding with more dispositive discipline of Respondent's license (Finding No. XVIII). Having thusly proceeded, the discipline undertaken by Colorado resulted in the filing of the Accusation (Finding Nos. I and VI). Other than references to Department of Alcoholic Beverage Control cases, neither counsel cites any appellate case involving the discipline of a professional license. While this tribunal is deeply concerned with the propriety of consecutive proceedings arising from the same underlying conduct, Complainant, citing 4 Witkin, California Procedure, 3d ed. 1985, §23, p. 66; Crowley v. Katleman (1994) 8 Cal.4th 666, 681 - 682, argues

> "that factual identity does not make the cause of action. Rather, a cause of action is determined by the violation of a primary right. There may be as many causes of action as there are violations of primary rights."

Complainant submits "there are two primary rights involved in complainant's prosecution of respondent for the summary suspension and the subsequent revocation, i.e., first, the right to be free of conduct so egregious that it warrants a summary pre-adjudication determination of suspension and, second, the right to be free of conduct sufficient to warrant the penalty of revocation following an adjudicative hearing." Of particular concern to this tribunal is the fact that Complainant in both actions, unlike Colorado, sought revocation with the concomitant result that in the first, Respondent's license was placed on probation. Nevertheless, not only is it axiomatic that the same set of facts may give rise to multiple prosecutions (Friedberg v. Cox (1987) 197 Cal.App.3d 381, 388), but also the pertinent sections of the Business and Professions Code (i.e., §141 and 2305) allow for the imposition of discipline each time a physician is disciplined by a foreign jurisdiction. Respondent's motion is dismissed.

Cause, accordingly, exists to revoke or suspend the license of Respondent pursuant to Business and Professions Code §§141, 2234 and 2305 for out of state discipline as set forth in Finding Nos. XVII - XIX.

II

Respondent sought by his Motion to Dismiss (see Determination of Issues No. I) to include, by such motion, the dismissal of the allegations in the First Amended Accusation referencing violations by Respondent of Business and Professions Code §2236 for conviction of a crime substantially related to the qualifications, functions, or duties of a Board licensee. Complainant objected to the timeliness of the motion which objection is overruled (Title 1, California Code of Regulations, §1022(f)). Respondent's motion argues that the conviction in

Colorado, stayed and presently appealed, is not final and, therefore, does not provide this tribunal with either subject matter jurisdiction or appropriate due process grounds upon which to proceed.

The evidentiary record does not wholly support Respondent's argument. The stay ordered by the District Court in Colorado affected only the execution of sentence not the fact of conviction (Finding No. XXI). The effect of Respondent's appeal does not function to vacate the fact of conviction (Finding No. XX) for purposes of Business and Professions Code §2236 as it now reads. Possessing subject matter jurisdiction to proceed, Respondent's motion is dismissed.

Cause exists to revoke or suspend the license of Respondent pursuant to Business and Professions Code §2236 for conviction of a crime substantially related to the qualifications, functions, or duties of a physician and surgeon as set forth in Finding Nos. XIX - XX.

III

Respondent, on February 9, 1998, objected to the imposition of costs in this matter claiming that any award is unconstitutional pursuant to California Teachers Association v. State of California (1997) 59 Cal.App.4th 516.[6]

Notwithstanding the untimeliness of Respondent's submission objecting to the imposition of costs, this tribunal deems it appropriate to overrule the objection for the following reasons:

A. This tribunal, extant in the executive branch of government, lacks the Constitutional jurisdiction to declare Business and Professions Code §125.3 unconstitutional.

B. Two California appellate courts have thusfar specifically upheld the efficacy of Business and Professions Code §125.3 as it relates to medical disciplinary proceedings. Schneider v. Medical Board of California (1997) 54 Cal.App.4th 351; Angelier v. Pharmacy Board of California (1997) 58 Cal.App.4th 592.

C. A medical disciplinary proceeding (Schneider, supra; Angelier, supra; Fahmy v. Medical Bd. of California (1995) 38 Cal.App.4th 810) is

[6] Respondent's objection was submitted without leave of this tribunal and after submission of the matter. It is untimely.

distinguishable from an employment dismissal proceeding (California Teachers Association, supra). Indeed, the import of the Legislature's provision for cost recovery is to provide some relief to the physicians and surgeons of California who contribute, by their dues and taxes, to the Board disciplinary system by the imposition of costs on errant licensees.

Cause, accordingly, exists pursuant to Business and Professions Code §125.3 to direct Respondent to pay $8,452.00 as reasonable costs in the investigation and enforcement of this matter as set forth in Determination of Issues Nos. I and II, and each of them, and Finding No. XXIII.

IV

Respondent, even by his own admission, acknowledges the egregious nature of his conduct on July 8, 1993. Involved in both administrative and criminal proceedings in Colorado, and notwithstanding the imposition of discipline in California allowing him to undertake the practice of medicine herein, he has yet to fully devote himself to his rehabilitation.

The objective of a disciplinary proceeding is to protect the public, the profession, maintain professional integrity, its high standards, and preserve public confidence in licensure. The statutes and regulations relating to physician licensing are designed to protect the public from dishonest, untruthful and disreputable licensees. Cf. Fahmy, supra; Arneson v. Fox (1980) 28 Cal.App.3d 440, 451.

In the practice of medicine, it is axiomatic that character is as important a qualification as knowledge (cf. Hawker v. New York (1897) 170 U.S. 189, 196; Dent v. West Virginia (1888) 129 U.S. 114, 122; cf. DeRasmo v. Smith (1971) 15 Cal.App.3d 601, 605; Harrington v. Department of Real Estate (1989) 214 Cal.App.3d 394, 406) and becomes of equal import in proceedings where a licensee has engaged in conduct comprising moral turpitude (Finding Nos. XIX.E and XXXII) and repeated acts of gross negligence (Finding Nos. XIX.D and XXXIII).

The key concern in disciplinary proceedings is the degree to which the public needs protection from Respondent. Mepham v. State Bar (1986) 42 Cal.3d 943, 948; In the Matter of Rodriguez (1993) 2 Cal. State Bar Ct. Rptr. 480, 501. In exercising disciplinary authority, this tribunal is compelled to consider towards protection of the public the underlying conduct of Respondent (Finding No. XIX), its nature and extent (Finding Nos. XXX and XXXII - XXXIII) and his rehabilitative efforts (Finding

Nos. XXIV - XXIX and XXXI) towards the protection of the public (Camacho, supra; Fahmy, supra). Such protection is singularly paramount.

The effect of Board licensure is to assure the public that the person holding the license is not only qualified but also maintaining the standards required in furthering the state's constitutional interest in public health, safety, morals and welfare. This places a burden not merely on the state but also upon the licensee to responsibly conduct his affairs. In this regard, it is Respondent who in the responsible conduct of his activities furthers public confidence in licensure.

Respondent's conduct (Determination of Issues Nos. I - II) is sufficiently egregious (Finding Nos. XIX, XXX and XXXII - XXXIII) when balanced against the evidence of mitigation (Finding Nos. XXIV - XXVIII) to compel a discipline that is not shared with the public by the imposition of probation but borne solely by Respondent.

Accordingly, giving due consideration to the facts and circumstances underlying the First Amended Accusation (Determination of Issues No. I - II), circumstances in mitigation and rehabilitation (Finding Nos. XXIV - XXVIII), and aggravation (Finding Nos. XXIX - XXIII), the public interest will be adversely affected by the continued issuance of a physician's and surgeon's certificate to Respondent at this time.

ORDER

I

The Physician and Surgeon's Certificate (No. C-34826) issued to Respondent Joseph J. Verbrugge, M.D., by the Medical Board of California is revoked as to Determination of Issues Nos. I and II, and each of them, and Determination of Issues No. IV.

II

Respondent Joseph J. Verbrugge, M.D. (Certificate No. C-34826), shall pay $8.452.00 forthwith to the Medical Board of California as costs in the investigation and enforcement of this matter pursuant to Determination of Issues No. III.

Dated: February 19, 1998

JAIME RENE ROMAN
Administrative Law Judge
Medical Quality Hearing Panel
Office of Administrative Hearings

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BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JOSEPH J. VERBRUGGE, M.D.** 6390 Locust Way Englewood, CO 80111 Physician's and Surgeon's Certificate No. C-34826, Respondent.	Case No. D1-93-29927 **FIRST AMENDED ACCUSATION**

The Complainant alleges:

PARTIES

1. Complainant, Ronald Joseph, is the Executive Director of the Medical Board of California (hereinafter the "Board") and brings this first amended accusation solely in his official capacity.

2. On or about February 2, 1973, physician's and surgeon's certificate no. C-34826 was issued by the Board to Joseph J. Verbrugge, M.D. (hereinafter "respondent"), and at all times

relevant to the charges brought herein, except as indicated hereinbelow, this license has been in full force and effect. Respondent's certificate expired on January 31, 1996, and is presently in delinquent status.

3. On January 21, 1994, Accusation number D-5650 was filed by the Board against respondent alleging violations of Business and Professions Code sections 2234 and 2305. The accusation was based upon the summary suspension by the Colorado State Board of Medical Examiners of respondent's Colorado medical license for gross negligence, failing to meet generally accepted standards of medical practice, and for falsifying a patient's medical records.

4. On July 25, 1994, a decision of the Board became effective by way of Stipulation in Settlement; Decision and Order. Respondent's California certificate was revoked, the revocation was stayed, and respondent was placed on five (5) years' probation with terms and conditions.

5. On November 27, 1995, Accusation number D1-93-29927 was filed against respondent alleging further violations of Business and Professions Code sections 2234 and 2305 in that on or about December 16, 1994, the Colorado State Board of Medical Examiners revoked respondent's Colorado medical license on grounds further indicated hereinbelow.

JURISDICTION

6. This accusation is brought before the Division of Medical Quality of the Medical Board of California, Department of

Consumer Affairs (hereinafter the "Division"), under the authority of the following sections of the California Business and Professions Code (hereinafter "Code"):

A. Section 2227 of the Code provides that the Board may revoke, suspend for a period not to exceed one year, or place on probation, the license of any licensee who has been found guilty under the Medical Practice Act.

B. Section 2234 of the Code provides that unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct which would have warranted the denial of a certificate."

C. Section 2236 of the Code provides that the conviction of any offense substantially related to the qualifications, functions or duties of a physician and surgeon constitutes unprofessional conduct.

D. Section 2305 of the Code provides that the revocation, suspension, or other discipline, restriction, or limitation imposed by another state upon a license or certificate to practice medicine issued by that state, or the revocation, suspension, or restriction of the authority to practice medicine by any agency of the federal government, that would have been grounds for discipline in California of a licensee under the provisions of the Medical Practice Act, shall constitute grounds for disciplinary action for unprofessional conduct against the licensee in this state.

E. Section 125.3 of the Code provides, in part, that the Board may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act, to pay the Board a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

F. Section 141 of the Code provides that a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice of medicine may be grounds for disciplinary action by the Board against a holder of a California physician's and surgeon's certificate.

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FIRST CAUSE FOR DISCIPLINE

(Out-of-State Discipline)
[Bus. & Prof. Code §§ 141, 2234, 2305]

7. On December 16, 1994, the Colorado State Board of Medical Examiners revoked the license to practice medicine in the State of Colorado of respondent, who specializes in the practice of anesthesiology. The initial decision in respondent's case made the following finding, inter alia: "the proved charges in this matter are extremely serious, indicating a disturbing lack of vigilance, care and judgment on Respondent's part as well as a disregard for his obligations with respect to accurate and truthful charting. This is true regardless of whether the actual cause of death in this matter was malignant hyperthermia or prolonged respiratory compromise combined with exogenous heating. In either event, Respondent's substandard actions included conduct which fell grossly below acceptable standards of medical practice, which covered multiple aspects of his care of [patient] R.L., and which likely resulted in R.L.'s death. Such actions clearly merit imposition of substantial discipline ... Taken as a whole, Respondent's statutory violations in combination with his behavioral difficulties indicate he presents a serious risk for future unsafe medical practice." (See Exhibit A attached hereto.)

8. As a result of respondent's conduct for which his Colorado medical license was revoked as indicated in paragraph 7, above, and the discipline of revocation imposed as indicated therein, respondent is subject to discipline under Code sections

2234, 2305 and 141.

SECOND CAUSE FOR DISCIPLINE

(Conviction of Crime Substantially Related)
[Bus. & Prof. Code § 2236]

9. On or about October 22, 1996, respondent was convicted of criminal medical negligence in Denver District Court, Denver, Colorado for his part in the death of patient R.L. in case number 95CR-002256, People of Colorado v. Joseph J. Verbrugge. (See Exhibit B attached hereto.)

10. Respondent's conviction as set forth in paragraph 9, above, constitutes conviction of a crime substantially related to the qualifications, functions or duties of a physician and surgeon and therefore unprofessional conduct subject to discipline within the meaning of Code section 2236.

PRAYER

WHEREFORE, complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division issue a decision:

1. Revoking or suspending physician's and surgeon's certificate number C-34826, heretofore issued to respondent Joseph J. Verbrugge, M.D.;

2. Revoking, suspending or denying approval of respondent's authority to supervise physician assistants, pursuant to Business and Professions Code section 3527;

3. Ordering respondent to pay the Division the actual and reasonable costs of the investigation and enforcement of this

case;

4. Taking such other and further action as the Division deems necessary and proper.

DATED: 11-27-96.

Ronald Joseph
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

forms\accuse [115 rev]

EXHIBIT A

BEFORE THE STATE BOARD OF MEDICAL EXAMINERS

STATE OF COLORADO

ME 93-06

FINAL BOARD ORDER

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS REGARDING THE LICENSE TO PRACTICE MEDICINE IN THE STATE OF COLORADO OF JOSEPH J. VERBRUGGE, JR., M.D., LICENSE NO. 18269,

Respondent.

The matter came before Hearing Panel B of the Colorado State Board of Medical Examiners ("the Hearing Panel") for review of the initial decision of Administrative Law Judge Judith F. Schulman ("the ALJ") issued in the above referenced case on May 17, 1994. That decision is incorporated by reference as though fully set forth herein, with the exception of Appendix A to the initial decision which has been sealed from public inspection.

On June 16, 1994 Respondent filed exceptions to the initial decision and exceptions to Appendix A and requested oral argument.

On June 24, 1994 Petitioner Inquiry Panel A filed a response to Respondent's exceptions and designation of record.

On July 12, 1994 Respondent thereupon filed a reply to Panel's response to Respondent's exceptions and designation of record.

The Hearing Panel granted Respondent's request for oral argument.

On November 18, 1994, Hearing Panel B considered the initial decision of the ALJ, including Appendix A, the subsequent pleadings filed by the parties as noted above, and the designated portions of the hearing record. The Hearing Panel also heard oral argument by the parties. Present during oral argument and deliberations was conflicts counsel from the Office of the Attorney General.

After due consideration of the record, and otherwise being fully advised in the premises, Hearing Panel B pursuant to Sections 12-36-118(5)(g)(III) and 24-4-105, C.R.S., makes the following FINDINGS AND CONCLUSIONS:

1. The ALJ's findings of fact are supported by the record, and are affirmed and adopted by the Hearing Panel.

2. The ALJ's conclusions of law are supported by the record, and are affirmed and adopted by the Hearing Panel.

3. Respondent's exceptions to the initial decision of the ALJ are not supported by the record, and are rejected by the Hearing Panel.

Respondent argues that his conduct constituted an isolated lapse and does not warrant the revocation of his license by the Board. Further, Respondent urges the Board to place his license on probationary status using an elaborate scheme he has proposed, and argues that such action is sufficient to serve the public interest.

After a lengthy evidentiary hearing, the ALJ concluded otherwise, noting that:

" . . . the proved charges in this matter are extremely serious, indicating a disturbing lack of vigilance, care and judgment on Respondent's part as well as a disregard for his obligations with respect to accurate and truthful charting. This is true regardless of whether the actual cause of death in this matter was malignant hyperthermia or prolonged respiratory compromise combined with exogenous heating. In either event, Respondent's substandard actions included conduct which fell grossly below acceptable standards of medical practice, which covered multiple aspects of his care of R.L., and which likely resulted in R.L.'s death. Such actions clearly merit imposition of substantial discipline. . . Taken as a whole, Respondent's statutory violations in combination with his behavioral difficulties indicate he presents a serious risk for future unsafe medical practice." (Initial decision, page 34)

The Hearing Panel, after careful review of the ALJ's initial decision, including mitigating factors, concurs with the decision of the ALJ.

THEREFORE, IT IS ORDERED that the license to practice medicine in the State of Colorado of Joseph J. Verbrugge, Jr., M.D., is hereby revoked.

This decision becomes final upon mailing. Any party adversely affected or aggrieved by any agency action may commence an action for judicial review before the Court of Appeals within forty-five (45) days after such action becomes effective. Reference Sections 24-4-106(11) and 12-36-119(2), C.R.S.

Dated and signed this 16th day of December, 1994.

FOR THE COLORADO STATE BOARD OF MEDICAL EXAMINERS
HEARING PANEL B

Member

Member

Member

Member

Member

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I have this 19th day of December, 1994, placed a true and correct copy of the Final Board Order regarding the license to practice medicine of Joseph J. Verbrugge, Jr., M.D, in the United States mail, postage paid thereon, addressed to:

David A. Burlage, Esq.
Montgomery Little & McGrew, P.C.
5445 DTC Parkway, Suite 800
Englewood, CO 80111

Robert N. Spencer, Assistant Attorney General
Colorado Department of Law
Regulatory Law Section
1525 Sherman Street, 5th Floor
Denver, CO 80203

Joyce M. Echelmeier
Joyce M. Echelmeier
Secretary

FOR THE COLORADO STATE BOARD OF MEDICAL EXAMINERS

BEFORE THE STATE BOARD OF MEDICAL EXAMINERS
STATE OF COLORADO

CASE NO. ME 93-06

INITIAL DECISION

IN THE MATTER OF DISCIPLINARY PROCEEDINGS REGARDING THE LICENSE TO PRACTICE MEDICINE IN THE STATE OF COLORADO OF JOSEPH J. VERBRUGGE, JR., M.D., LICENSE NO. 18269,

Respondent.

This is a disciplinary proceeding regarding the Colorado license to practice medicine of Joseph J. Verbrugge, Jr., M.D. ("Respondent"), brought by Inquiry Panel A ("Panel") of the State Board of Medical Examiners ("Board") pursuant to the provisions of the Medical Practice Act, Sections 12-36-101 to 137, C.R.S. (1991 and 1993) ("MPA"). Hearing was held in this matter on February 7 through 10, 15 through 18, and 22, 1994, before Administrative Law Judge Judith F. Schulman, Colorado Division of Administrative Hearings. The Panel was represented by Assistant Attorney General Robert N. Spencer; Respondent was represented by David A. Burlage, Esq., of Montgomery, Little & McGrew, P.C.

PRELIMINARY MATTER

During the course of the hearing, testimony was taken intermittently which related to certain peer review documents and proceedings of St. Joseph's Hospital. These matters are privileged and confidential pursuant to Sections 12-36.5-104(10)(a), (11) and (13), C.R.S. (1991), and Sections 25-3-109(1) through (4), C.R.S. (1989). As a consequence, by stipulation of the parties and order of the Administrative Law Judge, those portions of the hearing which related to peer review matters were closed to the public and peer review-related documents entered into evidence were sealed from public inspection. The matters thus sealed represent a small percentage of the total testimony taken and exhibits admitted in this matter.

In order to further protect the confidential and privileged status of the peer review matters in question, this Initial Decision is divided into two parts: this document, which is available to the public and addresses all non-privileged and non-confidential matters covered in the hearing, and Appendix A to this document which is sealed and which deals solely with peer review matters. Both sections are part of the Initial Decision in this matter issued pursuant to Section 24-4-

105(14)(a), C.R.S. (1993).

FINDINGS OF FACT

1. Respondent was licensed to practice medicine in Colorado on July 10, 1973, and was issued License No. 18269, which he has continuously held since that date. On July 16, 1993, Respondent's license to practice medicine in Colorado was summarily suspended based on allegations which form a substantial portion of the charges in the present proceeding. Respondent's license remains summarily suspended at this time.

2. At all times relevant to this matter, Respondent was engaged in the practice of medicine in Denver, Colorado. The patient care and medical practice issues which form the basis of this proceeding all occurred at St. Joseph Hospital, Denver, Colorado.

3. During all times relevant to this proceeding Respondent specialized in the practice of anesthesiology. Respondent received his medical degree from the University of Michigan in 1966, completed his anesthesia residency at the University of Colorado Health Sciences Center in 1973, and was certified by the American Board of Anesthesiologists in 1977.

4. Respondent established a physician-patient relationship with R.L., an eight year old boy, on or before July 8, 1993.

5. On the morning of July 8, 1993, R.L. was admitted to St. Joseph's Hospital for ear surgery, specifically, a right tympanoplasty and mastoidectomy to remove a cholesteatoma, a growth of skin tissue in the ear. This procedure, while meticulous and time-consuming, was not expected to pose any significant risk to R.L.

6. At the time of this surgery, R.L. was otherwise healthy. He had previously undergone uneventful surgery with general anesthesia.

7. Respondent acted as the sole anesthesiologist for R.L.'s July 8, 1993, surgery and as such was in charge of providing and monitoring anesthesia for R.L.

8. During the course of the morning surgery, R.L. suffered elevated heart rate, tachypnea (elevated respiratory rate), hypercarbia (elevated levels of carbon dioxide in the blood), hyperthermia, severe metabolic disturbances and cardiac arrhythmias. R.L. ultimately suffered a cardiopulmonary arrest at 11:00 a.m., at which point a COR was called. A five-hour effort to resuscitate the patient was unsuccessful and he was declared dead at 4:00 p.m.

9. Shortly after the COR was called blood gases were drawn which revealed a PCO_2 (partial carbon dioxide) of 200 (normal is 40); a PO_2 (partial oxygen) of 23 (normal is greater than

100); a pH of 6.71 (normal is 7.35-7.45) and a base excess of minus 18 (normal is 0). Although there is some uncertainty as to whether this was an arterial blood gas or a venous sample, in either event this blood gas is extremely abnormal and inconsistent with life. For example, the pH shows extreme acidosis and the PCO_2 shows extremely high concentrations of CO_2 in the patient's blood. In addition, the patient had an extremely elevated temperature of 42° C (107° F) at approximately this time and was extremely hyperkalemic.

10. Respondent was made aware in advance of surgery that the procedure would last 3-4 hours.

11. On the morning of July 8, 1993, Respondent saw R.L. and his mother prior to surgery, reviewed the patient's history and physical, and obtained an additional history at that time. R.L.'s vital signs at 7:15 a.m. were normal, including a low-normal temperature of 97° F. Based on the history and physical, Respondent listed the patient as an ASA (American Society of Anesthesiologists) Category 1 patient (least surgical risk). At this point a determination was made to use mask inhalation anesthesia which was appropriate under the circumstances.

12. Respondent then went to the operating room where he utilized his own personal unwritten checklist to check operating room and anesthesia equipment, machines and supplies in preparation for R.L.'s surgery which was the first surgery of the day scheduled for that particular operating room.

13. Machines and monitors to be used during this procedure included the anesthesia machine and breathing circuit, which supplies and monitors inhalation agents and gases to the patient; the mass spectrometer machine, which monitors, among other things, end-tidal carbon dioxide ("ET CO_2"), and concentration of inspired oxygen; a Nihon-Codon machine which monitors pulse, blood pressure and heart rate, an EKG, and a pulse oximeter which measures pulse and oxygen saturation in the blood.

14. R.L. was brought into the operating room at approximately 7:40 a.m. and anesthesia induction began at 7:45 a.m.

15. Prior to surgery Respondent did not calibrate the anesthesia machine's oxygen analyzer which measures the concentration of oxygen in the gas going to the patient from the anesthesia machine through the breathing circuit. The procedure for calibrating the oxygen analyzer on the anesthesia machine takes approximately 1-2 minutes and assures the delivery of a proper concentration of oxygen to the patient. Such calibration involves no risk to the patient.

16. During R.L.'s surgery there were two independent systems in place to monitor delivery of a proper oxygen concentration to the patient since the mass spectrometer measures this value independently of the oxygen analyzer on the anesthesia machine.

17. All calibrations concerning the mass spectrometer, including the oxygen concentration readings, are performed on a periodic basis by specialized technicians; anesthesiologists do not calibrate this machine. In contrast, it is routine and recommended practice for anesthesiologists to calibrate the anesthesia machine's oxygen analyzer prior to the first case each day in any given operating room.

18. At the time Respondent set up the anesthesia machine for R.L.'s surgery and throughout the surgery the anesthesia machine's warning light, which reads "O_2 Cal Due," was illuminated, indicating the analyzer had not been calibrated.

19. In order to assure delivery to the patient of proper concentrations of oxygen, the generally accepted standard of medical practice for anesthesiologists in 1993 ("applicable standard of care") required anesthesiologists to calibrate the oxygen analyzer on the anesthesia machine prior to commencing the first surgery of the day, regardless of whether or not a mass spectrometer machine would be in use during the surgery. Although a significant portion of anesthesiologists in 1993 (perhaps 20%) did not calibrate the oxygen analyzer when a mass spectrometer was in use, such conduct was contrary to St. Joseph's Hospital's own guidelines for anesthesiologists and was contrary to acceptable, safe practice and applicable standards of care. Furthermore, in this instance Respondent did not have faith in the mass spectrometer machine, having had occasions where the machine stopped functioning entirely during surgery. Under these circumstances, the applicable standard of care required Respondent to calibrate the oxygen analyzer on the anesthesia machine, rather than relying on the oxygen sensor for inspired gases on the mass spectrometer, which machine Respondent thought to be unreliable. Respondent's failure to calibrate the oxygen analyzer on the anesthesia machine prior to R.L.'s surgery therefore failed to meet applicable standards of care, particularly under the circumstances of this case. There is no evidence or claim that the failure to perform this calibration caused any subsequent harm to the patient.

20. Just prior to anesthesia induction, Respondent placed EKG pads, activated the pulse oximeter, and turned the mass spectrometer on. Respondent placed an inhalation mask on the patient and started with 100% oxygen and a small amount of the chosen inhalation agent, halothane. Because R.L. was somewhat resistant, Respondent switched briefly to a higher level of halothane (3.5%) to successfully induce a more rapid sleep state. Once the patient was settled, halothane concentration was reduced. Following induction, a blood pressure cuff was placed and an intravenous line was started, and Respondent placed a 5.0 uncuffed RAE endotracheal tube ("ET tube") after visualizing the vocal cords and determining that the expected tube size of 6.0 or 5.5 (based on R.L.'s age) would be too large. Respondent then taped the tube in place, placed an esophageal stethoscope and temperature probe in the patient's esophagus and connected the breathing circuit.

21. The purpose of placing the ET tube is to maintain an airway and to assure proper delivery of gases and inhalation agents to the patient during surgery and proper expiration of carbon dioxide. Improper placement of the ET tube (for example, in the hypopharynx or esophagus or too far into the trachea so that the ET tube goes into one bronchostem only and

delivers gases and inhalation agents to only one lung) will compromise or prevent such delivery and expiration.

22. There is a dispute in the evidence as to whether Respondent, following the intubation, checked for proper placement of the ET tube by auscultating the patient's chest with a stethoscope for bilateral breath sounds.

23. Respondent testified he was "pretty sure" that after the intubation he used a stethoscope to listen to bilateral breath sounds. Respondent indicated that following this, he put his stethoscope in his briefcase, probably locking the briefcase at that time because he did not anticipate needing the stethoscope further during the case and wanted to safeguard the stethoscope in light of a history of losing stethoscopes in the operating room. In contrast, Mary Kay Harrell, the circulating nurse during the procedure, whose memory of the events was very detailed, testified that she was right next to Respondent during the intubation and observed the intubation. According to Harrell, Respondent did not auscultate the patient with a stethoscope following the intubation and, in fact, never had a stethoscope at any time during the procedure. Similarly, Karen Latson, scrub nurse during the surgery, did not see Respondent with a stethoscope at any time during the procedure and specifically never saw Respondent use a stethoscope after the intubation. In light of Respondent's uncertainty concerning this issue in comparison especially to Harrell's clear memory of the events, as well as the questionable reliability of Respondent's recall and testimony as discussed below, the Administrative Law Judge finds that Respondent did not auscultate R.L.'s chest for bilateral breath sounds following the initial intubation.

24. The applicable standard of care in 1993, as indicated by the weight of the expert testimony presented at hearing and by various authoritative treatises admitted into evidence, required that following intubation in a surgical setting the patient's chest must be auscultated with a stethoscope for bilateral breath sounds. The purpose of doing so is to assure that the patient has a patent, properly placed airway. Although a significant number of anesthesiologists in 1993 did not routinely auscultate a patient's chest with a stethoscope for bilateral breath sounds after intubation but instead relied on various monitors to check for ET tube patency, such conduct was contrary to recommended, accepted and safe medical practice. Auscultation with a stethoscope following intubation is particularly important where, as here, an uncuffed RAE tube is being used (as is appropriate with a child this age) since there is a greater danger with an uncuffed tube (as opposed to a cuffed tube) of improper tube placement or having the tube dislodged when the patient is repositioned during surgery. Furthermore, assuring and maintaining an airway is especially critical during surgery involving children and exact ET tube placement is more critical with a child than an adult since the range of appropriate placement in a child is smaller. While there are other means (which were apparently used by Respondent) that are helpful in checking the patency and proper placement of an airway following intubation, including observation of chest movement when the lungs are inflated with oxygen and checking the ET CO_2 readings on the mass spectrometer, these methods are not infallible. Although auscultation is also not infallible because of the possibility of misinterpretation by the physician, it provides valuable additional information concerning the airway and may, on occasion, be the only indication of a

misplaced ET tube. Furthermore, auscultation is non-invasive, requires minimal time and effort to perform, and presents no risk to the patient. Respondent's failure to auscultate R.L.'s chest with a stethoscope following the initial intubation therefore failed to meet generally accepted standards of care. There is no evidence or claim that R.L.'s ET tube was, in fact, improperly placed or not patent immediately following the initial intubation.

25. In connection with this surgery, two exogenous (external) heat sources were used to counteract the tendency of children during long procedures to become hypothermic. Specifically, a K-thermia heating mattress was in use, set at 41° C. In addition, during surgery Respondent utilized a Concha-therm machine which heats and humidifies gases delivered to the patient through the breathing circuit. Respondent initially set the Concha-therm at 38° C and apparently reduced the temperature to 36° C at 9:30 a.m. However, it registered 42° C shortly after 11:00 a.m. In addition, R.L. was completely draped, except for the surgical site, with essentially impermeable drapes which had the effect of trapping heat around the patient.

26. Although Respondent properly inserted an esophageal stethoscope and temperature probe following intubation, Respondent never connected either device to a monitor. Therefore, no functional temperature probe or esophageal stethoscope was in use at any time during R.L.'s procedure.

27. Temperature monitoring during surgery is done to assure the patient does not develop dangerous hypothermia or hyperthermia.

28. The most common complication of pediatric anesthesia is hypothermia.

29. The temperature probe which Respondent initially inserted in R.L.'s esophagus but never connected to a monitor had been placed on the operating room pediatric cart for use in the R.L. case. After placing the probe in the patient's esophagus, Respondent attempted to connect the other end of the probe to a temperature monitor box in the operating room only to find that the probe and box were incompatible. Respondent then learned for the first time that the monitors had been newly changed by the hospital but the operating room had not been equipped with new matching probes; instead, only probes matching the old monitor boxes were present in the OR. At this point, Respondent had several options for obtaining proper temperature monitoring capability during the surgery. Respondent could have requested a new probe to match the new monitor box which was present in the operating room or he could have requested an old monitor box to match the already-inserted old temperature probe. Respondent chose the latter course of action: he requested that an old monitor, compatible with the already-placed temperature probe, be brought into the operating room.

30. The requested temperature monitor box was delivered to the operating room within five to ten minutes of Respondent's request. By that time prepping and draping the patient for surgery was in progress or completed and actual surgery may have been in progress. Respondent

elected not to connect the temperature probe to the monitor. Such connection would have required Respondent to lift the drapes on the patient.

31. There was no emergency which required R.L.'s surgery to begin immediately. Nothing would have prevented Respondent, upon learning of the incapability between the temperature probe and the monitor box, from requesting a delay in prepping, draping and commencing surgery until a compatible monitor could be obtained. Further, even without a delay in prepping, draping and commencement of surgery, had Respondent proceeded to go under the drapes to connect the temperature probe when the compatible monitor arrived, such action would have posed no threat to the surgical field under the circumstances of this case because the connection could have been made without violating the sterile field.

32. Once a temperature probe had been placed in the patient's esophagus no further risk to the patient was posed by connecting the probe to a monitor box.

33. Use of a temperature probe and continuous temperature monitoring is required by applicable standards of care at a minimum in any surgery where temperature reasonably may be expected to fluctuate, including:

a. Procedures anticipated to be lengthy, including procedures of 3-4 hours;

b. Procedures involving children since children are known to experience temperature swings during surgery; and

c. Procedures where exogenous heating sources are in use.

34. In light of the fact that each of the above factors was present in connection with R.L.'s surgery, it was imperative in accordance with applicable standards of care to utilize continuous temperature monitoring during R.L.'s surgery. Further, the fact that the inserted temperature probe and monitor box initially present in the operating room were not compatible did not alter Respondent's obligation to continuously monitor R.L.'s temperature during the surgery under the facts of this case.

35. Respondent admits that his conduct in failing to continuously monitor R.L.'s temperature during this surgery failed to meet applicable standards of care. He blames himself, not the hospital's mixup with the probes, for the failure to monitor and admits that he had a clear opportunity to ask that the draping be stopped or to connect the probe even after the draping was completed.

36. Respondent's failure to continuously monitor R.L.'s temperature during his surgery constituted an extreme departure from the ordinary standard of care in the community and was so deviant from the accepted minimal standard as to be beyond the bounds of professional tolerance ("grossly negligent medical practice").

37. At the time of the intubation Respondent was situated at the patient's head. Following intubation, various monitors and the breathing circuit were temporarily disconnected to allow the operating table to be rotated 180°. This rotation placed the surgeon at the patient's head for proper access to the surgical site and resulted in Respondent being situated for the surgery at R.L.'s feet. Upon completion of the rotation, all previously connected monitors and the breathing circuit were reconnected.

38. Although at the beginning of surgery Respondent had inserted an esophageal stethoscope (it was attached to the esophageal temperature probe), Respondent at no time had any intention of connecting the esophageal stethoscope to a monitor and, in fact, never did so. As a consequence, the esophageal stethoscope was not functional or in use at any time during the surgery.

39. Respondent did not use any type of stethoscope during the course of R.L.'s surgery to monitor breathe sounds or for any other purpose.

40. Although there was a problem, as described above, of incompatibility between the esophageal temperature probe inserted by Respondent and the monitor box initially available in the operating room, there was no such incompatibility problem with regard to the esophageal stethoscope placed by Respondent and the appropriate monitor connection, nor did Respondent think any incompatibility problem existed. Further, once the combined temperature probe/esophageal stethoscope had been placed in the patient's esophagus, there was no additional risk to R.L. in connecting the esophageal stethoscope to a monitor so it could be functional and utilized during surgery.

41. The purpose of an esophageal stethoscope is to permit continuous monitoring of bilateral breath sounds during surgery. (In addition, the esophageal stethoscope serves as a monitor of heart sounds.) Where, as here, the patient is fully draped and rotated 180° from the anesthesiologist, an esophageal stethoscope was the only available means to monitor breath sounds continuously in order to detect any airway problem.

42. The applicable standard of care under the circumstances of this case required continual monitoring of bilateral breath sounds with a stethoscope. Specifically, applicable standards required the use of a precordial stethoscope during anesthesia induction to detect a laryngospasm. (At this point in the procedure a child has no IV in place for quick administration of drugs to counteract such an occurrence, so early detection of laryngospasm is particularly important.) In addition, because the patient was fully draped and rotated 180° from the anesthesiologist, the applicable standard further required that following initial induction a switch be made from a precordial stethoscope to continuous use of an esophageal stethoscope during the remainder of surgery. The need for an esophageal stethoscope was further heightened by the fact that during this particular type of surgery a number of changes in the tilt of the table (including use of the Trendelenburg position which tilts the patient into a head-down position) and the patient's head position were anticipated. Such changes increase the chance of dislocating the

airway, an event which continuous monitoring with the esophageal stethoscope is likely to detect. Respondent's failure to utilize a precordial stethoscope during anesthesia induction and his failure to utilize an esophageal stethoscope during the remainder of the procedure constituted substandard medical practice.

43. Respondent's failure to utilize continuous temperature monitoring and his failure to utilize an esophageal stethoscope are implicated in his failure to detect the emerging crisis later suffered by R.L.

44. Surgery began at approximately 8:20 a.m. and was uneventful for approximately the first hour. Throughout the surgery the surgeon utilized a microscope to assist his vision and had only a minimal idea of Respondent's movements and actions. Apparently after initially using higher halothane concentrations (3.5%) during induction, sometime during the early stages of surgery Respondent went to a 2% alveolar concentration of halothane to assure no involuntary patient movement. (Respondent made no chart note of this or any other concentration of gases or inhalation agents utilized during surgery.)

45. There is no dispute that following anesthesia induction until at least 10:30 a.m. the patient was breathing on his own (spontaneous respirations).

46. Between approximately 9:15 and 9:30 a.m. Respondent became concerned that as a consequence of the Trendelenburg (head down) position the patient was in, condensate from the heated, humidified breathing circuit was moving toward the patient and creating a potential for aspiration of the liquid. Respondent discussed this issue with the surgeon. In addition, as noted, Respondent testified he dropped the Concha-therm temperature from 38° to 36° C at this time. He also testified he drained condensate from the breathing tube by temporarily disconnecting the breathing circuit and draining condensate onto the floor and/or back into the Concha-therm reservoir. None of the nurses in the room observed this conduct and Respondent did not chart that he had done this. Nevertheless, the Administrative Law Judge finds that Respondent did take this action on at least one occasion between 9:15 and 9:30 a.m.

47. Between 9:30 and 10:00 a.m. the surgeon requested Respondent to make a number of changes in the tilt of the operating room table, which Respondent did as requested.

48. ET CO_2 (end-tidal carbon dioxide) is a measurement of the concentration of expired CO_2 and can be used to determine adequacy of ventilation. Between approximately 8:20 a.m. and 9:30 a.m. Respondent charted the following ET CO_2 values: 40.6 between 8:15 and 8:30 a.m.; 47.3 between 8:30 and 8:45 a.m.; 48.2 between 9:00 and 9:15 a.m.; and 50.2 at 9:30. With the exception of a chart entry at 10:45 a.m. (15 minutes before the COR) of 64, the accuracy of which is extremely suspect for reasons set forth below, these are the only ET CO_2 chart entries Respondent made during the entire surgery.

49. Respondent has admitted that subsequent to 9:30 a.m. he had adequate time periodically to chart ET CO_2 readings, but failed to do so.

50. One of the important purposes of anesthesiology charting is to note trends as they develop to assure vigilance and adequate response to developing patient conditions which might not otherwise be noticed.

51. The applicable standard of care in the community required anesthesiologists to continuously monitor ET CO_2 levels during surgery and contemporaneously to chart ET CO_2 levels at a minimum of every 15 minutes.

52. Respondent admits that the 64 ET CO_2 value that appears on the second page of his anesthesiology chart at 10:45 a.m. was not charted contemporaneously but instead was entered by Respondent after 4:00 p.m. following the unsuccessful five-hour resuscitation effort and the patient's ultimate death. Furthermore, Respondent's explanation of how he was able to recall that value more than five hours later is unconvincing. Thus, there is no basis for believing that the 10:45 a.m. ET CO_2 value which appears in the chart is accurate. Consequently, Respondent did not contemporaneously or accurately chart any ET CO_2 readings after 9:30 a.m. and his failure to do so constituted a failure to meet applicable standards of care with respect to charting.

53. ET CO_2 levels and readings reflect a patient's respiratory status and, when closely observed and properly interpreted, provide valuable information relating to whether a patient is properly ventilated so as to permit adequate expiration of CO_2. This information is obtained by means of an ET CO_2 digital read out of CO_2 concentrations and a graphical wave form display. In order for the numerical ET CO_2 level to be accurate, the graphical ET CO_2 curve must be in the form of a plateau rather than a sinusoidal wave.

54. As of 9:30 a.m. Respondent noticed a trend of rising ET CO_2 values (from 40.6 at the beginning of surgery to 50.2 by 9:30 a.m.). Respondent apparently believed that R.L.'s rising ET CO_2 was a sign of deepening levels of anesthesia. Consequently, according to Respondent, at approximately 9:30 a.m., he lightened the level of anesthesia. Although there is no chart note indicating Respondent took this action, the Administrative Law Judge finds that he did so.

55. Respondent asserts that although he did not chart ET CO_2 levels after 9:30 a.m. (except once at 10:45 a.m.), he continued to observe the patient's ET CO_2 levels on a regular basis up until the time of the COR. The Administrative Law Judge finds, however, that while Respondent observed and charted ET CO_2 levels up to 9:30, he failed to closely observe the patient's ET CO_2 levels after 9:30 a.m. based on the following factors:

a. The Administrative Law Judge finds Respondent's 10:45 a.m. ET CO_2 chart entry of 64 is not accurate. The entry was made more than five hours after the supposed

occurrence and Respondent's explanation for why he was able to remember this particular value so long afterward, particularly after the turmoil of a five-hour resuscitation effort culminating in the patient's death, is contradicted by other testimony in the case; is inherently inconsistent; and is unconvincing. Thus, there is no record of the patient's CO_2 levels at any time after 9:30 a.m. until the first blood gases were drawn during the COR shortly after 11:00 a.m., showing a PCO_2 of 200. The Administrative Law Judge infers that in this case the failure to record these levels reflected a failure to closely observe the levels..

b. Respondent at no time testified what the patient's specific ET CO_2 levels were during surgery between 9:30 a.m. and 10:30 a.m. or after 10:30 a.m., other than indicating that the values were rising. (According to Respondent's testimony, he believes the patient's ET CO_2 reached 64 at 10:30 a.m., even though he belatedly charted it at that level at 10:45, not 10:30.) Respondent failed, for example, to indicate what the approximate ET CO_2 level was shortly before the COR, a value that presumably Respondent would likely recall after the event and testify about had he been closely observing these levels.

c. Statements made by Respondent in connection with the St. Joseph's peer review process also support this conclusion. See Appendix A.

56. The applicable standard of care required an anesthesiologist to closely and continuously observe the ET CO_2 curve and levels during the entire course of R.L.'s surgery. Because Respondent did not do so after 9:30 a.m., his conduct in this regard was substandard.

57. Respondent admitted that subsequent to approximately 10:30 a.m. he failed contemporaneously to record the patient's blood pressure and pulse. (Respondent charted these values following the COR on the second page of his anesthesia record but admits his charting was grossly inaccurate. See Finding of Fact 122).

58. In order to assure vigilance and adequate response to developing conditions which might not otherwise be noticed, the applicable standard of care required anesthesiologists continuously to monitor blood pressure and pulse during surgery and contemporaneously to chart these values every five minutes during surgery except where clinical events prevent such charting.

59. Respondent had adequate time between 10:30 a.m. and approximately 10:55 a.m. contemporaneously to chart blood pressure and pulse readings every five minutes but failed to do so. This conduct constituted a failure to meet applicable standards of care.

60. Respondent's charting of pulse readings during various times between approximately 9:00 a.m. and 10:00 a.m. was substantially at variance with the patient's actual heart rates during this time as measured by the Nihon-Codon machine.[1/] For example, between 9:00 a.m. and approximately 9:20 a.m. Respondent's charting shows an unchanged pulse of 68, and from 9:30 to 9:40 a.m. a value of approximately 70. During this same period of time the Nihon-Codon shows a steadily increasing heart rate starting at 71 at 9:00 a.m. and ending at 88

at 9:40 a.m. (the 9:20 a.m. Nihon-Codon value is 77). Between 9:45 and 10:00 a.m. Respondent's chart does show an increasing pulse (80 at 9:45 and approximately 94 at 10:00 a.m.); however, the Nihon-Codon values, while also showing a trend toward increasing heart rate indicate significantly higher absolute heart rate values (*e.g.*, 90 at 9:45 and 110 at 10:00 a.m.).

61. The applicable standard of care required Respondent's pulse charting to be accurate. The degree of unexplained discrepancy (often as much as 10 points or more) between the pulse rates charted by Respondent from 9:00 to 10:00 a.m. and the actual rates and upward trends recorded by the Nihon-Codon constituted an unacceptable degree of inaccuracy and therefore failed to meet the applicable standard of care with respect to accurate charting.[2/]

62. At approximately 10:15 a.m. there was an inadvertent airway disconnect which did not indicate any inappropriate care by Respondent or anyone else.

63. The surgeon discovered the inadvertent disconnect in connection with hearing a gurgling sound from the patient and then mentioned it to the scrub nurse. Both the surgeon and the scrub nurse believe they noticed the disconnect before Respondent did and called it to Respondent's attention. Respondent apparently did not hear the gurgling. However, Respondent believes he noticed the disconnect prior to or simultaneous with it being called to his attention by the surgeon. In any event, upon becoming aware of the disconnect, Respondent stood up, walked to the other end of the table, lifted the drapes and reattached the breathing circuit. He then went back to the monitors where he asserts he checked ET CO_2 readings, and noted proper anesthesia bag excursion. Respondent testified that he believed this disconnect may have been associated with movements or actions of the scrub nurse or excess tension in the breathing circuit.

64. Following the 10:15 a.m. disconnect Respondent did not have an esophageal stethoscope placed or any other type of stethoscope available and did not check the patient's breath sounds to insure the patient's ET tube remained properly positioned.

65. The 10:15 a.m. airway disconnect accompanied by gurgling is consistent with a displaced airway or with a partially liquid obstruction such as mucous in the ET tube.

66. Although it is always a good practice to auscultate a patient's chest with a stethoscope following an airway disconnect, the applicable standard of care for the purpose of assuring a patent airway may not necessarily require such auscultation following a simple disconnect where bag excursion and the ET CO_2 readings return to normal immediately upon reconnection. However, the applicable standard of care did require Respondent to auscultate the patient's chest with a stethoscope for bilateral breath sounds following the inadvertent airway disconnect in this case because Respondent believed the disconnect may have been caused by movements or actions of the scrub nurse, thus raising the possibility that the patient's ET tube had become dislodged or misplaced in association with the disconnect and removing the incident from the category of a "simple" disconnect. (Furthermore, the fact of the patient's gurgling with spontaneous respirations, if Respondent had heard the gurgling, would have been an additional

independent reason to determine this was not a "simple" disconnect, but instead was one which raised the possibility of ET tube displacement or partial obstruction, requiring auscultation of the patient's chest for bilateral breath sounds with a stethoscope.) Given this additional factor, merely checking the bag excursion and ET CO_2 level and curve following the reconnect were inadequate actions to take in attempting to insure a patent airway, since such measures would not necessarily detect tube displacement in all cases. While auscultation is also not foolproof in this regard, it is likely to produce additional useful information concerning the airway status and is thus an action required by the applicable standard of care to be taken under the circumstances of this case. This is particularly true in this case since it involved a child where attention to the airway is especially critical and required heightened vigilance on the part of the anesthesiologist. Respondent's failure to auscultate R.L.'s chest for bilateral breath sounds following the 10:15 a.m. inadvertent airway disconnect therefore constituted substandard care.

67. At 10:30 a.m. R.L.'s blood pressure was 91/44; baseline blood pressure was 81/36. Oxygen saturation was 100% throughout the case until 9:30 when it fell to 98%. Oxygen saturation was 97% at 10:30 a.m. and remained at that level up to and including the time the COR was called shortly after 11:00 a.m.

68. Beginning at approximately 10:30 a.m. the patient began to develop signs and symptoms of malignant hyperthermia ("MH") and/or respiratory distress.

69. MH is a rare genetic disease which can result in an acute, dramatic increase in skeletal muscle metabolism upon exposure to inhalation anesthetics such as halothane. Without treatment, this increase in metabolism can quickly overwhelm the cardiovascular system, causing death. The increased metabolic rate of the skeletal muscles increases oxygen consumption above oxygen delivery and causes huge increases in carbon dioxide, lactate and heat production, as well as respiratory and metabolic acidosis, increased levels of potassium and muscle rigidity, among other things. Excess levels of acid and potassium affect the heart's ability to conduct electrical current and in essence poison the heart. Mortality from MH is currently estimated at 5-10%.

70. MH-susceptible patients cannot be identified in advance by physical examination and approximately one-half of the individuals who have experienced a clinical episode of MH have had at least one prior exposure to triggering anesthetic agents which did not result in the development of MH symptoms. It is thus unlikely that MH-susceptible patients will be identified prior to a clinical episode.

71. Classic signs of MH include elevated ET CO_2 concentrations (hypercarbia—often the first sign of MH), tachycardia (elevated heart rate) and tachypnea (elevated respiratory rate), all of which are early signs, as well as metabolic acidosis, skeletal muscle destruction hyperthermia and muscle rigidity.

72. A clinical episode of MH becomes increasingly more difficult, if not impossible, to stop as it progresses. Thus, early detection and treatment of MH is crucial. Once diagnosed,

appropriate treatment for MH includes withdrawal of the triggering agent and administration of dantrolene sodium which has the effect, if timely administered, of returning skeletal muscle metabolism to normal levels.

73. Signs of respiratory distress could include such things as elevated heart rate, tachypnea, evidence of inadequate ventilation such as high levels of ET CO_2 and irregular heart beat.

74. Excess CO_2 in the body, from whatever etiology, can cause an individual to want to breathe faster, resulting symptomically in an increased respiratory rate, an increased pulse and unstable blood pressure.

75. The patient's heart rate at the beginning of the procedure was approximately 66 beats per minute and rose steadily thereafter. By 9:35 a.m. the heart rate was 82 and by 9:40 it was 88. This represents an increase in heart rate of substantially more than 20% from the baseline value.[3/]

76. A rise in heart rate of 15 to 20% above baseline during surgery is a matter of concern to anesthesiologists. The applicable standard of care requires an anesthesiologist in the face of such an increase to take appropriate action to investigate the possible cause of such an increase. A common cause of such a rise is inadequate anesthesia. Thus, an appropriate initial response to a 15-20% rise in heart rate is to increase the level of anesthesia. If such anesthesia increase results in a corresponding decrease in heart rate it can be inferred that inadequate anesthesia was responsible for the heart rate increase. If such action does not result in a heart rate decrease, other appropriate measures must be pursued to determine the underlying cause of the heart rate increase.

77. The applicable standard of care required Respondent by 9:35-9:40 to take appropriate action to determine the cause of the patient's steadily rising heart rate. Respondent failed to take any such action and, in fact, apparently lowered the level of anesthesia at this time (although this is not charted) in an effort to respond to the patient's steadily increasing ET CO_2 levels. Respondent thus failed at approximately 9:40 a.m. to comply with applicable standards of care with respect to determining the cause of the patient's steadily increasing heart rate.[4/]

78. After 9:40 a.m. the patient's heart rate (and ET CO_2 levels) continued to rise. At 10:30 a.m. the heart rate was at 104 beats per minutes, representing a 50% increase over baseline.[5/] By this time, in the absence of a clear explanation for the steadily accelerating heart rate (the written record reflects no explanation), pursuant to the applicable standard of care it was imperative for Respondent to determine the underlying cause. Respondent, however, took no action at this time aimed at discovering the underlying cause of this developing ominous symptom.

79. At 10:30 a.m. R.L.'s respirations had increased to 53 per minute. The surgeon asked Respondent if it was possible to slow down the patient's breathing because it was interfering

with the surgeon's ability to operate. Respondent responded that he could do nothing unless the surgeon wanted Respondent to use a paralyzing agent on the patient which both physicians had previously agreed was not an acceptable alternative given the nature of this surgery.

80. The patient's accelerated respiratory rate of 53 under the circumstances of this case indicated extreme respiratory distress.

81. Prior to the surgeon calling this matter to Respondent's attention, Respondent had taken no action to determine the cause of or correct the patient's elevated respiratory rate, despite the fact that according to Respondent's own admission the rate was accelerated prior to this time.[6/]

82. Respondent concedes that he took no immediate action with respect to R.L.'s accelerated respiratory rate even after it was specifically called to his attention by the surgeon at 10:30 a.m.

83. However, Respondent asserts that at 10:40-10:45 a.m. he began to assist the patient's respirations by squeezing the anesthesia bag by hand consistent with the ET CO_2 curve and with normal bag feel. Respondent asserts he was able to obtain good compliance from the patient in doing so. Respondent further testified that the assisted respirations continued until approximately 10:50-10:55 a.m. when he placed the patient on mechanical ventilation.

84. In contrast, Respondent's narrative medical record summarizing the COR procedure notes the patient was breathing spontaneously at 10:55-11:00 a.m. when the COR was called, while the second page of Respondent's anesthesia record (filled out after the patient's death) indicates assisted respirations began at 10:45. (This record makes no mention at all of mechanical ventilation.) Furthermore, both the scrub nurse and the circulating nurse testified they never saw Respondent squeezing the anesthesia bag by hand at any time during the surgery and specifically did not see him respond in this manner to the surgeon's request for something to be done regarding the patient's accelerated respiratory rate.[7/]

85. After weighing the evidence, the Administrative Law Judge finds Respondent did not assist the patient's respirations by squeezing the anesthesia bag by hand in response to the surgeon's request to decrease the patient's respirations, or at any other time during the surgery. This determination is based on the following factors:

a. Although Respondent's records on this point are in conflict, he admitted at hearing that page 2 of his anesthesia record, which contains the assisted respirations reference and which was written directly after the patient had died and while Respondent was under great stress, is grossly inaccurate in most respects. In contrast, Respondent did not indicate that his narrative record (also written after the patient's death) was flawed to that extent.

b. The nurses who indicated they did not see Respondent assisting with the patient's ventilation were in a good position to observe Respondent and, in fact, were specifically

observing Respondent to see what his response would be to the surgeon's request to resolve the accelerated respirations problem as well as to evidence of irregular heart beats (see *infra*) which developed at approximately 10:45 a.m. There was no indication these nurses had any motive to fabricate their testimony nor was there any indication the testimony in this regard was unreliable.

c. Respondent's physical position during surgery was apparently inconsistent with his being able to squeeze the anesthesia bag with his right hand, which is the hand Respondent indicated he uses for this task.

d. Respondent's credibility concerning certain critical issues in the case is suspect in light of various inaccuracies, inconsistencies, misstatements and/or apparent misrepresentations made by Respondent concerning these issues at earlier stages of this proceeding. Furthermore, Respondent's testimony, records and past statements concerning the specific question of assisted ventilation have also been inconsistent and contradictory. His testimony concerning this matter is therefore suspect and is given less weight than that of other witnesses.

e. It is unlikely that effective assisted breathing from 10:40 or 10:45 a.m. until just before the COR at 11:00 a.m. could be consistent with the first blood gas drawn during the COR (at 11:07 a.m. or shortly thereafter) indicating a PCO_2 of 200.

f. Taking action to assist respirations is inconsistent with Respondent's statement to the surgeon that he could do nothing to control the patient's respiratory rate.

86. As noted, Respondent did not contemporaneously chart ET CO_2 levels after 9:30 a.m., when the ET CO_2 reading was 50.2. In addition, the Administrative Law Judge has found that the subsequently-charted ET CO_2 value of 64 at 10:45 is untrustworthy. Nevertheless, there is no dispute that the ET CO_2 value as reflected on the mass spectrometer was at least 64 at 10:30/10:45 a.m. and was steadily rising throughout the procedure beginning with a value of 40.6 recorded at approximately 8:15 a.m. Furthermore, it is possible that the actual ET CO_2 at 10:45 was substantially higher than 64 in order to account for the PCO_2 blood gas result at 11:07 or shortly thereafter of 200.[8/]

87. An ET CO_2 reading of 35 would be considered normal and readings in the low 40s or even 50 under anesthesia with spontaneous respirations are not unusual. Nevertheless, a rising ET CO_2 trend is significant. Such a trend is a possible sign of MH as well as a number of other things, including deepening anesthesia.

88. As noted, in response to the rising ET CO_2, Respondent testified that at 9:30 a.m. (ET CO_2 at 50.2) he lowered the anesthesia concentration, although this was not charted.

89. The evidence indicates any anesthesia reduction at 9:30 a.m. did not affect the patient's steadily increasing ET CO_2 level which reached a minimum of 64 at 10:30/10:45 a.m.

Nevertheless, according to Respondent's own testimony he did not further respond to the patient's rising ET CO_2 level until at least 10:40 a.m. when Respondent asserts he began hand ventilating the patient. Further, according to the findings of the Administrative Law Judge, Respondent did not take even this action in response to the patient's rising ET CO_2 level.

90. Respondent asserts that he mistakenly interpreted R.L.'s elevated ET CO_2, accelerated respiratory rate and accelerated heart rate as evidence of deep and deepening anesthesia and concedes that by 10:30 a.m. he should have realized that this was not the case and should have taken appropriate steps to determine and treat the patient's actual problem (which Respondent believes was MH). Respondent concedes his failure adequately to respond to the patient's symptoms from 10:30 on was substandard care. (He disputes the conduct was grossly negligent medical practice.)

91. As of 10:30 a.m. R.L.'s condition was clearly not consistent with a determination that the patient was merely indicating signs of deep and deepening anesthesia. On the contrary, by 10:30 a.m. the combination of elevated and steadily rising ET CO_2 values (in excess of 50 and perhaps as much as 64 or more), an accelerated respiratory rate of 53 and an accelerated heart rate of 104 constituted ominous evidence that R.L.'s condition was in fact seriously deteriorating, possibly as a result of developing MH and/or respiratory distress. As of this time, the applicable standard of care required Respondent to initiate aggressive action to determine the underlying cause of the patient's developing crisis and to take definitive treatment actions. Such required actions included investigating and assuring of the patency of the patient's airway by listening with a stethoscope for bilateral breath sounds (particularly in light of the inadvertent disconnect 15 minutes earlier); ascertaining the depth of anesthesia to determine the cause of the patient's heart rate increase; and taking the patient's temperature, since a significantly elevated temperature in the face of the patient's other symptoms and in the absence of an impaired airway would be an indication of likely MH. Other appropriate actions would include obtaining arterial blood gases to determine the patient's metabolic status. If a diagnosis of MH was then made, the standard of care would require immediate initiation of the MH treatment protocol, including administration of dantrolene sodium. Respondent, however, failed to take any of these required actions and his conduct thus fell below generally accepted standards of care. Furthermore, such failure constituted an extreme departure from the ordinary standard of care in the community and was so deviant from the accepted minimum standards as to be beyond the bounds of professional tolerance. Furthermore, even if Respondent did take action to hand ventilate the patient at approximately 10:40-10:45 a.m. or mechanically ventilate the patient at 10:50-10:55, such actions were totally inadequate since they merely attempted to ameliorate on a temporary basis the patient's immediate symptoms of accelerated respirations and rising ET CO_2 without determining and treating the underlying cause of these ominous symptoms. Because any such action, if it did occur, was not directed at identifying and treating the patient's underlying problem, it would not alter a determination that Respondent's conduct failed to meet applicable standards of care and was so deviant from accepted minimum standards as to be beyond the bounds of professional conduct.

92. At approximately 10:45 a.m. Mary Sue Harrell, the circulating nurse, heard tones on the pulse oximeter that she thought represented two sets of bigeminal heart beats. At that time Harrell looked at Respondent who did not look up or appear to react. Respondent was sitting in front of the anesthesiology machine looking down, hands in front of him in his lap. Harrell did not see Respondent hand ventilating the patient at this time.

93. Harrell then went to the EKG monitor, stood behind Respondent by the monitor and watched three sequences on the screen (approximately 18 seconds). What she observed were EKG complexes that were taller than at the beginning of the case but otherwise appeared to be consistent with a normal sinus rhythm. Harrell did not see anything that would explain the bigeminal beat. Respondent then looked at the monitor and did not seem concerned so Harrell went back to her operating room desk.

94. At hearing Respondent acknowledged that at approximately 10:45 he noticed a broad QRS complex on the EKG which was short-lived and which came to his attention because someone in the OR mentioned there was an arrhythmia Respondent stated he did not see the bigeminal beat on the EKG or hear evidence of it on the pulse oximeter. At the time, Respondent did not take any action specifically to respond to this heart beat irregularity. In retrospect Respondent believes the irregularity was consistent with hyperkalemia (excess potassium).

95. There was no obvious benign explanation for the irregular heart tones heard by Harrell and the broad QRS complex seen by Respondent.

96. Particularly in light of the events which preceded the irregular heart beats, these heart beats were extremely serious warning signs requiring Respondent's immediate attention and action. For example, EKG tracings meeting Harrell's and Respondent's descriptions are consistent with significant hyperkalemia. (At a potassium reading of 5-6 the T waves get taller and larger and as the potassium reading goes to 7-8 there is a widening of the QRS complex. In addition, bigeminal beats also can be caused by hyperkalemia.) These signs are ominous because such high levels of potassium can lead to heart stoppage resulting from an inability of the heart to conduct electrical impulses in the presence of excess potassium.

97. In light of all the events and conditions which preceded the patient's irregular heart beats at 10:45 a.m., the applicable standard of care required Respondent at 10:45 a.m. to react aggressively to determine the underlying cause of the patient's irregular heart beats. Respondent did not do so.

98. During the course of surgery and particularly from 10:30 a.m. on Respondent failed adequately to respond to the patient's accelerated heart rate, accelerated respiratory rate, elevated levels of CO_2 and evidence of irregularities in the patient's heart beat. Such signs and symptoms were evidence of either the patient's developing MH and/or respiratory distress; however, Respondent did not recognize them as such. Respondent's failure, individually and taken as a whole, to adequately respond to these signs and symptoms of the patient's developing crisis

constituted substandard care and care which consisted an extreme departure from ordinary community standards and was so deviant as to be beyond the bounds of professional tolerance.

99. Shortly after 11:00 a.m. Respondent noticed a "terminal" arrhythmia (nodal arrhythmia with PVC's). Respondent immediately administered 25mg Xylocaine. The condition then progressed to bradycardia, in response to which Respondent administered 0.4mg atropine. The patient then went into asystole (no heart beat). Respondent called a COR at approximately 11:00 a.m., turned off the halothane and continued 100% oxygen. At this time or shortly before this (10:50-10:55), the patient was placed on mechanical ventilation.

100. Respondent then moved to the patient's head and operating room personnel removed the patient's drapes. Respondent repositioned the patient slightly by removing a supporting shoulder roll and placing him on his back. The patient was pallid, but not cyanotic. Respondent noted that R.L. was very warm to the touch.

101. At approximately this point (20-30 seconds after the COR was called) anesthesiologist Steve Snidach, M.D., responded to the COR. Because Respondent was at the patient's head, Snidach went to the anesthesiology machine and turned off the ventilator in order to hand ventilate the patient. Upon attempting to squeeze the anesthesia bag, Snidach felt a tremendous resistance (peak inspiratory pressures in the high 50's) and was unable to move any air. He announced this loudly and checked for a pulse which he was unable to obtain. Respondent then administered a precordial thump and began chest compressions.

102. At this juncture (one to two minutes after Snidach's arrival) anesthesiologist Mark Wilson, M.D., arrived. Both he and Snidach asked loudly for a stethoscope several times. Respondent did not respond to their requests in any fashion and did not produce a stethoscope. In fact, at no time during the COR did Respondent ever produce or use his own stethoscope. A one-two minute delay ensued until a stethoscope was obtained by a nurse and provided to Wilson.

103. Upon receiving the stethoscope Wilson auscultated the patient for bilateral breath sounds and was unable to hear any. He announced this loudly. Verbrugge then immediately extubated the patient, briefly breathed the patient with a mask, and then reintubated the patient with a 5.5 cuffed RAE tube. Following reintubation, Wilson was able to hear good breath sounds upon auscultation and Snidach was able to bag the patient easily.

104. The ET tube removed from the patient was 50% occluded by a mucous plug. The plug was not covering any of the ET tube's three portals.

105. At approximately this point Snidach noted that the Concha-therm machine was registering 42° C, indicating gases were being delivered to the patient at this temperature. This temperature was excessive and was causing the breathing circuit plastic tubing to become deformed (early stages of melting). Snidach therefore turned off the humidifying unit.

106. Wilson then inquired if epinephrine had been given and Respondent indicated that it had not. Wilson asked if Respondent wanted Wilson to give some epinephrine and Verbrugge responded affirmatively. At this point Wilson asked what dose Respondent wanted and Verbrugge responded that he would "have to calculate" the dose. Without giving Verbrugge time to calculate the dose, Wilson administered first 100 micrograms, then 200 and 400 micrograms until a rhythm was obtained.

107. As soon as he determined at the beginning of the COR that R.L. felt hot, Respondent believed R.L. had MH. Respondent immediately attempted to obtain a temperature probe to confirm the diagnosis and an MH cart to initiate the MH treatment protocol. Verbrugge obtained a temperature probe approximately 6-7 minutes into the COR and determined the patient's temperature was 42.1° C. He then initiated the MH protocol.

108. An ultimately unsuccessful five hour resuscitation effort was conducted involving numerous physicians and other hospital personnel. Resuscitation efforts included administration of numerous drugs, contact and advice from the national MH hotline and placing the patient on a heart-lung bypass machine. Along with other individuals present, Respondent intermittently administered chest compressions to the patient during the COR.

109. During the course of the COR, in cooperation with other physicians attending the COR, Respondent properly executed the MH protocol.

110. At the time of the COR Respondent did not attempt to confirm the existence of a patent airway and breathing before initiating measures to support circulation because he believed these were established just prior to the COR.

111. At the time of the COR the patient's oxygen saturation was at 97%. The patient was therefore adequately oxygenated when the COR was initiated. Adequate oxygenation, however, is not a measure of adequate ventilation.

112. Respondent asserts that beginning shortly before the COR he was ventilating the patient mechanically with 100% oxygen. Thus, according to Respondent, the issue of an airway was taken care of by the ET tube and breathing was taken care of because the patient was receiving 100% oxygen through the ventilator and breathing circuit. Respondent asserts he knew the tube was patent because the oxygen saturation was 97%, the ET CO_2 wave forms were appropriate, and the patient was not cyanotic. Respondent therefore asserts that at the time of the COR he was not required to recheck the patient's airway and breathing. His explanation for the inability of Wilson and Snidach to obtain bilateral breath sounds and to ventilate the patient is that the ET tube became obstructed with mucous and/or dislodged after the COR began, either through repositioning the patient or performing chest compressions.

113. Given the small amount of patient movement that occurred at the time the COR began, it is unlikely that the ET tube became dislodged as a result of that movement. In addition,

it is unlikely, but not impossible, for a mucous obstruction to occur during the course of chest compressions.

114. As the anesthesiologist in charge during the surgery, it was Respondent's responsibility to take charge initially of the COR when it was called.

115. The applicable standard of care required an anesthesiologist in charge at the time a COR is called to assure the existence of a patent airway and breathing before proceeding with measures designed to address circulation (CPR). Here, within approximately one minute of the COR being called the patient did not have a patent airway and was not breathing, yet at the time of the COR Respondent proceeded to address circulation and temperature issues without first assuring the existence of the airway and breathing. Such conduct failed to meet applicable standards of care even though just prior to the COR Respondent believed the patient had a patent airway and was breathing since such belief did not have a reasonable basis. Even according to Respondent's version of the events, as much as 10 minutes prior to the COR he was not squeezing the anesthesia bag by hand but instead had the mechanical ventilator on. In addition, according to the facts as found by the Administrative Law Judge, Respondent at no time hand ventilated the patient and turned on the mechanical ventilator within a short time of the COR. Thus, under either version of the events, just prior to the COR Respondent did not have the added knowledge related to patient compliance and feel of bag excursion that comes from hand ventilating. Further, the Administrative Law Judge has already found Respondent had no stethoscope available to auscultate the patient's chest for bilateral breath sounds prior to the COR being called and was not carefully monitoring ET CO_2 readings and wave forms at this time. Under these circumstances Respondent was required at the time the COR was called to assure the patient had a patent airway and was breathing by auscultating the patient's chest for bilateral breath sounds. His failure to do so constituted substandard care.

116. The applicable standard of care required Respondent, as the anesthesiologist during the surgery and thus the physician in initial charge of the COR, to have available during the surgery and the COR and to make available during the COR to any other assisting physician who requests it, a stethoscope to facilitate diagnosis of the patient. Respondent's failure to have a stethoscope immediately available and to produce it upon request to Wilson and Snidach constituted conduct which failed to meet applicable standards of care.

117. The applicable standard of care required Respondent when he was performing chest compressions to continue to perform them at an adequate level and without stopping, except for brief periodic monitor checks to determine if administered drugs were effective. The Panel claims Respondent inappropriately stopped performing chest compressions during the periods of time when it was his responsibility to perform them. However, the evidence, which was in conflict, failed to establish that Respondent stopped performing chest compressions for reasons other than appropriately to check monitors for possible patient response to administered medications. Nor did the evidence establish the length of these pauses was excessive. Therefore, the evidence did

not establish Respondent's conduct with respect to performing chest compressions was substandard.

118. The applicable standard of care required Respondent to be familiar with the appropriate sequence, choice and dosages of resuscitative medications for his patient. There was no evidence that Respondent's knowledge or actions were in any way inappropriate with respect to atropine and Xylocaine. However, a question is raised with respect to epinephrine. As physician in charge of the COR, it normally would be Respondent's responsibility to determine the appropriate sequence and dosage of resuscitative drugs. However, a COR is a team effort and it is not necessarily substandard for the physician in charge to allow other physicians to recommend resuscitative drugs and dosages to be given to the patient, especially where the physician in charge is addressing other treatment issues. Nevertheless, it would be substandard for the physician in charge not to be aware of a proper dosage. In this case, once an airway and breathing hand been established and chest compressions were underway, Respondent's actions in focusing on obtaining a temperature probe and initiating the MH protocol for suspected MH were appropriate. Further, Wilson did not give Respondent an opportunity to calculate the appropriate epinephrine dose (which is calculated in general terms even in COR situations according to patient weight) before administering dosages himself. Thus, the evidence failed to establish that Respondent was unaware of the appropriate epinephrine dose and the evidence failed to establish that Respondent's actions with respect to the administration of epinephrine were in any other way substandard.

119. The patient developed significant masseter spasm and/or muscle rigidity at approximately 1:30 p.m.

120. Treatment of the patient during the COR included administration of dantrolene and use of exogenous cooling devices. After this treatment, at approximately 3:00 p.m., the patient's muscles began to relax; however, resuscitation remained unsuccessful. Respondent pronounced the patient dead at 4:00 p.m. and went to notify R.L.'s parents. Shortly after this, Respondent returned to the operating room in a very upset and distraught condition and attempted to complete his charting.

121. Respondent asked Delia Garcia, R.N., for R.L.'s anesthesia records. Garcia gave Respondent both pages of the existing anesthesia records. The first page of this record contained Respondent's charting for R.L.'s case until 10:30 a.m., when he ran out of room. The second page, which Respondent had originally requested be provided to him in blank at approximately 10:30-10:35 a.m. and which was provided to him by a nurse no later than 10:40 a.m., had in fact not been charted on at all during the surgery or, at a maximum, had only a few entries on it when Respondent received it after 4:00 p.m.

122. Upon receiving both pages of the anesthesia record after 4:00 p.m., Respondent remarked to Garcia that he was trying to chart the events of the surgery from memory and proceeded to attempt to fill in the chart. He wrote quickly and randomly for a short time,

announced he had made an error (apparently indicating an incorrect time on the chart), and requested a new second sheet. Respondent crumpled up the rejected page 2 and discarded it. He was given a new blank page by Garcia and proceeded again to attempt to recreate the events from memory. The end product was a chart with, among other things, blood pressure and pulse entries at five minute intervals from 10:30 to 11:00 a.m., oxygen saturation levels at 10:30, 10:45 and 11:00 a.m., and one ET CO_2 entry of 64 at 10:45 a.m. Each of these entries was written more than five hours after the events Respondent purportedly was charting, without reference to any notes and without any notation on the chart that the charting had been done after the fact. Respondent admitted at hearing that most of the entries on page 2 of the chart are grossly inaccurate, but asserts in his defense that he had no intent to falsify the records; instead, according to Respondent, he was merely doing his best to complete the chart at a time of much emotional turmoil for him.

123. At the same time that he filled in page 2 of the record Respondent also made at least one addition to page 1 of his record, adding the notation "BBS" (bilateral breath sounds) adjacent to his entry concerning R.L.'s initial intubation.

124. After doing his charting, Respondent insisted that Garcia sign off on the first page of his chart (he did not ask her to sign the second page) to verify the first page had been created during surgery. Respondent was apparently concerned about possible allegations of falsification of his charts based on a comment during the resuscitation by Snidach or Wilson that the patient had not been charted on. Prior to asking Garcia to sign off on page 1 of the chart, Respondent did not tell Garcia that he had made any additions on that page. Respondent did not note on page 1 that his "BBS" entry had been made after the fact.

125. Despite Respondent's distraught condition at the time he filled out page 2 of the anesthesia record, he was aware that the added entries were not or could not be accurate in light of the fact that the entries on their face purported to be contemporaneous patient vital signs generally at five minute intervals when in fact they were written more than five hours after the fact without the aid of notes and following an extended and harrowing resuscitation effort.

126. Respondent's chart entries for R.L. constituted incorrect or incomplete entries in the following respects, each of which involve essential chart entries:

a. Respondent's notation on page 1 regarding "BBS" was inaccurate. In addition, it was intentionally false because Respondent did not listen to the patient's breath sounds and was aware of that fact when he added this chart entry.

b. Respondent's chart contains no notation of the type or amounts of anesthetic administered before and during surgery, including any changes in the anesthetic concentration.

c. Respondent's chart contains no indication of the quantities/concentrations of oxygen being administered during surgery.

d. The chart contains a notation that one of the monitors in use during surgery was an esophageal stethoscope when, in fact, Respondent did not use an esophageal stethoscope and did not intend to use one at the time he made that notation on the chart.

e. The second page of the chart contains incorrect and incomplete entries for pulse, blood pressure and ET CO_2 levels.

f. The first page of the chart contains significantly inaccurate information concerning the patient's pulse.

127. On various occasions during the early part of R.L.'s surgery and particularly between 9:30 and 10:00 a.m., Respondent was noted by nursing personnel to be, and in fact was, slumped in his chair with his head on his chin, his eyes closed, and his arms crossed in front of him. Respondent claims he was not asleep but merely had his eyes closed and was listening to the pulse oximeter (the monitor upon which he relies most heavily), which has audible tones reflecting pulse, oxygen saturation and any changes in those values. He states he was too busy during this period assisting with table movements as requested by the surgeon and disconnecting, draining and reconnecting tubing coming from the Concha-therm to have fallen asleep. However, during this time Respondent's head was noted to bob from side-to-side at various times and he was noted to be motionless at various intervals over a 20-minute period. The Administrative Law Judge finds that between approximately 9:30 and 10:00 a.m. Respondent on various occasions was asleep for short periods of time or otherwise failed to remain alert and vigilant. This finding is based on the following factors:

a. Both the circulating and the scrub nurse saw Respondent in this posture during approximately this time period. One did not want to believe Respondent was asleep but the other stated persuasively and with certainty that she saw Respondent's head nodding on various occasions. This indicates a sleep state or extreme lack of alertness and lack of vigilance.

b. The period of time in question overlaps with Respondent's failure to keep accurate vital sign records concerning the patient and is therefore consistent with a period of sleep, lack of alertness and/or lack of adequate vigilance.

c. A finding of sleep or lack of alertness or vigilance is not inconsistent with the fact that Respondent followed periodic instructions by the surgeon during this period of time to move the table. The sleep state need not have been a deep one that prevented Respondent from being awakened by the surgeon's requests, nor was it continuous for a half hour period. However, Respondent's sleep state or lack of alertness was sufficient to render Respondent motionless with periodic head nodding while he was in that state and to prevent him from properly noting the patient's vital signs for a period of time.

d. In deposition testimony prior to the hearing, Respondent expressed some uncertainty as to whether he was asleep during part of the surgery. Such uncertainty is

inconsistent with having been fully awake and alert throughout the procedure. An individual who is fully alert and awake would certainly have no hesitancy about that fact; only someone who intermittently fell asleep or who was not alert throughout the procedure would have gaps in his memory so as to express such uncertainty.

128. The applicable standard of care required anesthesiologists to remain awake, alert and vigilant throughout all surgical procedures for which they have anesthesia responsibility. Respondent's failure to remain awake, alert and vigilant during R.L.'s surgery constituted a failure to comply with such standards and constituted an extreme departure from the ordinary standards of care in the community and was so deviant from accepted minimum standards as to be beyond the bounds of professional tolerance.

129. There is no definitive way to determine at this point when the mucous plug first entered R.L.'s ET tube and whether or not it built up gradually. It is also not possible to determine definitively at this date whether the mucous plug was of a sufficient size and viscosity and was present for sufficient period of time to account for, along with hyperthermia, all of the patient's signs and symptoms beginning at 10:15 or 10:30 in the absence of another event, such as an ET tube kink or misplacement or MH. It is known, however, that a 50% occlusion of a patient's breathing tube such as existed here at the time of the COR increases resistance to breathing by 16 times. Thus, the mucous plug had the potential to cause significant respiratory compromise for R.L.

130. Misplacement or obstruction of R.L.'s ET tube (including a mucous plug, tube kink, or partial misplacement after initial proper placement of the tube), or some combination of these factors is consistent with the peak inspiratory pressures noted by Snidach at the time of the COR, as well as the patient's condition at the time of the COR and the patient's first blood gas results.

131. As noted by most of the experts who testified, the cause of R.L.'s death cannot be determined definitively based on the evidence available. A substantial amount of evidence supports the Panel's theory that the death was caused by a prolonged period of hypoventilation (beginning up to 30-45 minutes prior to the COR) in combination with iatrogenic (exogenous) heating (heating caused by sources outside the patient). However, there is also evidence to support Respondent's theory that the patient died from MH (including the opinion of one of the Panel's experts who is a leading authority on MH and the opinion of the pathologist who performed the autopsy on R.L.).

132. Factors which are supportive of the prolonged respiratory distress/hypoventilation and iatrogenic heating theory include:

a. The presence of two separate exogenous sources of heating (the Concha-therm and heating blankets) plus drapes which were essentially impermeable could produce hyperthermia at the level seen in this patient, thus mimicking heating found in MH patients. This

is particularly true in this case where the Concha-therm gases at the time of the COR were apparently 42° C.

b. The first blood gas results, especially the PCO_2 of 200 which, if arterial, support a determination of significant, undetected, compromised and inadequate ventilation for a period of approximately 30 or more minutes before the blood gas was drawn.[2]

c. The sequence from 10:15 a.m. forward when there was an inadvertent airway disconnect accompanied by gurgling (consistent with a possible airway problem beyond a simple disconnect), followed at 10:30 by excessive respirations, increased heart rate and rising ET CO_2 levels, and by irregular heart beats at 10:45 a.m., is consistent with the existence of prolonged hypoventilation.

d. The lack of airway and breathing at the time of the COR.

e. The ET tube removed during the COR which was 50% occluded.

133. However, some of these same factors, as well as others, also support a diagnosis of MH. For example:

a. There is a distinct possibility that the original blood gas drawn during the COR was actually a venous sample, rather than arterial. In addition, because the lab equipment in question is inaccurate at such high PCO_2 levels, the true PCO_2 reading from the first blood gas could range between 120 and 240. It is also possible that the gas was drawn as much as 10 or 12 minutes into the COR instead of approximately 5 minutes after the COR was called. If the gas was venous, the PCO_2 was closer to 120 than 200, and the gas was drawn as much as 10-12 minutes into the COR, the death cannot be explained on the basis of a respiratory event alone (hypoventilation), but must involve a metabolic component such as MH.

b. Other factors which are consistent with MH and typical of MH include the patient's extremely elevated temperature, rising ET CO_2, increased pulse and sympathetic nervous system symptoms, high potassium levels, and muscle rigidity. However, none of these factors is inconsistent with hypoventilation and iatrogenic heating as a cause of death.

134. There are a number of factors (including some of those listed above) which are potentially consistent with either explanation of the patient's death including the patient's CPK reading (this was abnormally high, but not as high as might be expected for MH under certain conditions); his rising CO_2; his elevated temperature; his base excess reading (this was a significantly acid number but perhaps not as high a negative number as would be expected from MH); his oxygen saturation levels; his muscle rigidity (this can be explained as a rigor mortis-like contraction developing prior to death and within a short time of the COR in the face of the patient's highly elevated temperature or as muscle rigidity associated with MH); his highly acidic pH (which could show the generation of CO_2 from hypoventilation or the generation of acids of

metabolic origin); the inability, despite heroic efforts, to resuscitate the patient who had a healthy eight-year-old heart; and the patient's hyperkalemia (7.7 meq/l) shortly after the COR.

135. Whether the first blood gas was arterial or venous, it is nevertheless apparent that the values obtained (even allowing a margin of error for instrument inaccuracy at such high levels) could not have been reached solely between the time of the COR and the time the sample was drawn. Instead, the problems which resulted in the extremely abnormal blood gas readings had to be ongoing (and were unrecognized and not acted upon by Respondent) for a substantial period of time before the COR was called. In fact, it is likely that whatever the genesis of R.L.'s difficulty (MH or respiratory insufficiency), it began approximately 30 minutes before the COR was called (approximately 10:30 a.m.).

136. Determinations contained in this Initial Decision concerning Respondent's substandard and grossly substandard medical practice are unaffected by the cause of R.L.'s death. Whichever the cause, Respondent failed to observe (in some cases) and to appreciate and timely act on R.L.'s developing ominous signs and symptoms. It is these failures, rather than the cause of death, that is determinative of the standard of care issues.

137. If R.L. had MH and if Respondent had detected and treated it in a timely manner, there is a 90% chance R.L. would have survived. If R.L. was suffering from hypoventilation and iatrogenic heating and these problems had been detected and corrected in a timely manner, there is no reason to believe the patient would not have survived.

138. Following R.L.'s death, Respondent suffered from acute depression. Beginning July 12, 1993, Respondent sought psychiatric treatment from Dr. Robert Cowan and has continued regular treatment with Dr. Cowan since that time.

139. At the time Respondent first began psychiatric treatment, he was suffering from acute anxiety and depression relating to R.L.'s death. He was diagnosed as having major depression or depressive disorder NOS (not otherwise specified) with a history of chronic depression since at least 1991. Following R.L.'s death Respondent was treated with antidepressants initially for depression and then in low doses for sleep. Respondent had previously sought treatment in 1989 and 1991 in relation to family and marital issues which appear now to have resolved.

140. In addition to his depressive disorder Respondent also has a mixed personality disorder[10] characterized by a provocative style of interacting with others, a poor communication style, and passive-dependent and passive-aggressive features. Respondent's current therapy is addressing each of these issues.

141. In November 1993 Respondent underwent extensive neuropsychological testing. The results of this testing indicate that Respondent's neuro-cognitive abilities are intact and do not pose a threat to safe medical practice.

142. Respondent does not have a mental disorder or disability which would render him unable to practice medicine with reasonable skill and safety. Specifically, Respondent's depressive disorder is now in remission and Respondent's prognosis in this area is good. Although the disorder should continue to be treated (Respondent remains in therapy at this time), it does not pose a threat to Respondent practicing medicine safely.

143. Similarly, the undisputed evidence indicates that Respondent's personality disorder also does not render Respondent unsafe to practice medicine. Despite his personality disorder, Respondent has a capacity to change his maladaptive communication and interpersonal styles. However, the prognosis for altering personality disorders in general is guarded, and Respondent's personality disorder makes it difficult for him to choose to change. Taken as a whole, the evidence indicates Respondent is unlikely to make meaningful changes in these behavior patterns.

144. There is no evidence that would indicate any physical or specific psychological problem has contributed to Respondent's nodding off while in surgery.

145. Respondent presented a detailed proposed probation plan of open-ended length (at the Board's sole discretion) with practice monitoring including 100% chart review, verification of alertness in surgery by nursing personnel, unannounced direct observations in surgery and regular reporting by Respondent's approved practice monitor, ongoing psychotherapy, CPHP monitoring and reporting, and extensive continuing medical education. Respondent's probation plan also includes a proposal for evaluation of Respondent's anesthesia and communication skills as a prerequisite to the Board granting probation. Such evaluation procedure might require a limited license.

DISCUSSION

Count I

Respondent is charged in Count I in having engaged in unprofessional conduct in violation of Section 12-36-117(1)(p) of the MPA (grossly negligent medical practice or two or more acts or omissions which fail to meet generally accepted standards of medical practice) in connection with his care and treatment of R.L.[11/]

In the case of a medical professional, compliance with generally accepted standards requires the licensee to exercise that degree of knowledge, skill and care exercised by other like professionals in the same or similar circumstances. *Kibler v. State*, 718 P.2d 531 (Colo. 1986); *Lee v. State Board of Dental Examiners*, 654 P.2d 839 (Colo. 1982); *Artist v. Butterweck*, 162 Colo. 365, 426 P.2d 559 (1967).

Where the acts or omissions of a medical professional constitute an extreme departure from the ordinary standard of care in the community and are so deviant from the accepted minimum standards as to be beyond the bounds of professional tolerance, that professional's care

falls within the definition of grossly negligent medical practice. *People ex rel Woodard v. Brown*, 770 P.2d 1373 (Colo. App. 1989) *cert. den.* 783 P.2d 1223; *see Lee v. State Board of Dental Examiners, supra.*

The Administrative Law Judge has found that Respondent engaged in numerous acts and omissions with respect to his treatment of R.L. which failed to comply with applicable standards of care. These include Respondent's failure to adequately monitor R.L. during surgery (including his failure to monitor temperature, his failure to use a stethoscope to monitor breath sounds and ensure proper ET tube placement after the inadvertent airway disconnect, and his failure adequately to monitor ET CO_2); as well as Respondent's failure to adequately respond to evidence of R.L.'s developing MH and/or respiratory distress during surgery (as indicated by R.L.'s accelerated respiratory and heart rates, his elevated ET CO_2 and evidence of irregularities in R.L.'s heart beat). In addition, Respondent's substandard conduct included his failure to take immediate steps to ascertain the adequacy of R.L.'s airway and breathing at the time the COR was called and Respondent's failure to produce a stethoscope during the COR. Further, Respondent's charting was inaccurate and inadequate in a number of respects.

The Administrative Law Judge has also found Respondent's failure to use a stethoscope to check the patient's breath sounds after intubation and his failure to calibrate the anesthesia machine's oxygen analyzer constituted substandard care. With respect to these latter omissions,[12] Respondent argues his care fell within applicable standards because a significant minority of physicians do not calibrate the anesthesia machine's oxygen analyzer prior to surgery and do not use a stethoscope to check a patient's breath sounds after intubation.

Respondent relies on the testimony of one of his experts to the effect that while calibration of the oxygen analyzer and checking bilateral breath sounds with a stethoscope after intubation are recommended, such actions are not required because a "significant number" of anesthesiologists do not do so. In contrast, the Panel relies on experts who testified that such actions are required by the applicable standard of care. The uncontradicted testimony of these experts indicated that calibrating the oxygen analyzer and checking bilateral breath sounds with the stethoscope after intubation present no risk to patients, provide additional assurances of safety to patients (additional assurance the patient is receiving appropriate oxygen from the anesthesia machine and additional assurance of proper placement of the ET tube), and require minimal time and effort by the anesthesiologist to accomplish.

The fact that "some" or even a "significant number" of anesthesiologists do not take these precautions does not establish such conduct is consistent with the applicable standard of care. In the face of the Panel's testimony establishing the majority of anesthesiologists would take these actions, Respondent must show that a "respectable minority" of anesthesiologists would approve of the course of action taken by Respondent: specifically, his failure to calibrate the oxygen analyzer and his failure to auscultate with a stethoscope following intubation. *Hamilton v. Hardy*, 37 Colo. App. 375, 549 P.2d 1099 (1976). The evidence fell short of establishing this. Testimony on behalf of Respondent failed to show that the actions (or inactions) of the minority

on this issue are considered an acceptable alternative medical practice, *cf. Hamilton v. Hardy*, *supra*. Respondent's evidence, viewed in the light most favorable to him, merely showed a significant number of anesthesiologists do not take these precautions, not that the failure to do so is a respected practice. Thus, Respondent failed to show that his actions were consistent with those of a respected minority of anesthesiologists or consistent with safe practice. This is particularly true here where (as to the 0_2 analyzer) Respondent had no faith in the mass spectrometer; and where taking the precautions in question posed no risk to the patients, involved minimal time and effort on the part of the anesthesiologist, and had the potential to avert major medical disasters. Further, there has been no showing of any reasonable medical basis for failing to take the actions suggested. Consequently, Respondent's actions in this regard failed to meet generally accepted standards of care.[13/]

Thus, Respondent's actions as set forth above constituted two or more acts or omissions which failed to meet generally accepted standards of medical practice in violation of Section 12-36-117(1)(p), as charged in Count I.

The Administrative Law Judge has also found that a number of Respondent's acts or omissions which failed to meet generally accepted standards of care in addition constituted an extreme departure from the ordinary standard of care in the community and were so deviant from accepted minimum standards as to be beyond the bounds of professional tolerance. Respondent's actions falling into this category were his failure to employ a functioning temperature probe to monitor R.L.'s temperature; his failure by 10:30 a.m. to respond appropriately to R.L.'s accelerated respiratory rate, accelerated heart rate and elevated ET CO_2 as well as his failure at 10:45 a.m. to respond appropriately to evidence of irregularities in R.L.'s heart beat; and his failure to remain awake, alert and vigilant during surgery. Each of the above actions thus independently constituted grossly negligent medical practice in violation of Section 12-36-117(1)(p), as charged in Count I.

The Panel has charged but failed to establish Respondent prematurely stopped his efforts at chest compressions during the COR and failed to demonstrate adequate knowledge of the proper sequence, choice, and dosage of resuscitative drugs. The Panel has therefore failed to establish any violations of Count I with respect to these allegations.

Count II

Respondent is charged in Count II with unprofessional conduct with respect to R.L.'s medical records. Specifically, Respondent is charged with having falsified or repeatedly made incorrect entries or repeatedly failed to make essential entries on a patient's records, in violation of Section 12-36-117(1)(cc).

Respondent, in essence, concedes that he repeatedly made incorrect entries or failed to make essential entries on the patient's record. Specifically, he has admitted, and the

Administrative Law Judge has found, that he failed to note the type or amount of anesthetic and the quantities of oxygen administered before and during surgery, which entries are essential entries. Respondent also concedes he charted that one of the monitors in use during surgery included as an esophageal stethoscope when this was not the case. Respondent also admits he made numerous substantially inaccurate and incorrect entries regarding pulse, blood pressure and ET CO_2 levels on page 2 of the patient's anesthesia record when he tried to recreate these matters following the COR. Further, the Administrative Law Judge has found Respondent's entry of "BBS" on page 1 is incorrect because Respondent did not in fact auscultate the patient's chest after the intubation. The Administrative Law Judge has also found that Respondent's entries concerning R.L.'s pulse at various times between 9:00 and 10:00 a.m. were substantially inaccurate.

There can be no question that the chart entries and omissions described above constituted repeated incorrect essential entries and repeated failures to make essential entries in R.L.'s record, in violation of Section 12-36-117(1)(cc), as charged in Count II.

Respondent is also charged with having falsified R.L.'s patient record. Respondent argues that while his after-the-fact charting was inaccurate, he had no intent to falsify the records. He asserts he was merely attempting to complete the record to the best of his ability; he was distraught and not thinking clearly when he charted the second page; and although he did not note on the chart that it was completed after the fact, he specifically told Nurse Garcia that he was attempting to reconstruct the events from memory.

The Panel, on the other hand, claims Respondent's failure to note on the chart that it was being completed after the fact, along with his misstatements on page 1 concerning bilateral breath sounds and the use of an esophageal stethoscope indicate Respondent intentionally falsified substantial portions of the patient's record and acted with reckless disregard for the truth of what he was charting.

"Falsify", according to *Webster's New Twentieth Century Dictionary* (2nd Ed. 1983) means "to make false, specifically to misrepresent; give an untrue or misleading account of . . .". False, in turn, is defined as "not true, untruthful, lying, dishonest . . .". Particularly when juxtaposed against the language of Section 12-36-117(1)(cc) regarding making incorrect chart entries, it is clear that "falsify" in Section 117(1)(cc) requires proof of both a false statement (false representation) and an element of scienter. The latter is satisfied if the scienter elements of fraudulent misrepresentation and common law fraud are established. *Cf. Eckley v. Real Estate Commission*, 752 P.2d 68 (Colo. 1988) (the term "substantial and willful misrepresentation" under the Real Estate Licensing Law refers to common law fraudulent misrepresentation).

In Colorado the elements of common law fraud include: (1) a false representation of a material fact; (2) made with knowledge of the falsity or utter disregard as to its truth or falsity; and (3) with intent that it be acted upon. *Morrison v. Goodspeed*, 100 Colo. 470, 68 P.2d 458 (1937); *Concord Realty Co. v. Continental Funding Corp.*, 776 P.2d 1114 (Colo. 1989); *Palmer v. A.H. Robbins Co., Inc.*, 684 P.2d 187 (Colo. 1987). Furthermore, a representation which is

true as far as it goes, but which the maker knows or believes to be materially misleading because of the failure to state additional or qualifying matter is a fraudulent misrepresentation. *Eckley v. Real Estate Commission, supra. See also Patridge v. Youmans*, 107 Colo. 122, 109 P.2d 646 (1941); *Otis & Co. v. Grimes*, 97 Colo. 219, 48 P.2d 788 (1935); and *People v. Rader*, 822 P.2d 950 (Colo. 1992) (reckless disregard for the truth of statements made satisfies the scienter requirement in civil fraud proceedings).

The evidence establishes Respondent falsified R.L.'s records within the meaning of Section 117(1)(cc). By charting that an esophageal stethoscope monitor was in use during the procedure when Respondent knew at the time he so charted that he had no intention of using one, Respondent made a false representation of a material fact (an essential entry) knowing the chart entry was false at the time it was made. Similarly, at the time Respondent entered "BBS" on page 1 of the chart, he knew this material entry was untrue.

Furthermore, with regard to the pulse, blood pressure and ET CO_2 entries on page 2, all of which were material and made five hours after the event and without reference to any notes, Respondent could have had no hope of reconstructing even a minimally accurate record in the face of the passage of time and the nature of the intervening events. The fact that Respondent told Nurse Garcia he was creating the record from memory does not alter this conclusion. Respondent's disclosure to Garcia did not indicate his entries were wholly inaccurate, nor did Respondent make a note indicating his entries were merely guesses, which was actually the case. In the absence of such disclaimers, Respondent's chart entries constituted an implicit representation that he believed the entries were accurate. Because he did not and reasonably could not have had such a belief at the time the entries were made, Respondent's entries constituted a falsification. Finally, with respect to all the entries at issue, there can be no question that Respondent intended the entries to be relied upon since the entries were made in official medical records. The fact that Respondent was distraught at the time he made these entries, while perhaps a mitigating factor, does not alter the fact that he acted, at a minimum, with utter or reckless disregard for the truth and thus falsified the records within the meaning of Section 12-36-117(1)(cc), as charged in Count II.

CONCLUSIONS OF LAW

1. The Panel has jurisdiction over Respondent and the subject matter of this proceeding.

2. Respondent has engaged in unprofessional conduct in violation of Section 12-36-117(1)(p) by engaging in grossly negligent medical practice and two or more acts or omissions which failed to meet generally accepted standards of medical practice, as alleged in Count I.

3. Respondent has engaged in unprofessional conduct in violation of Section 12-36-117(1)(cc) by falsifying and repeatedly making incorrect essential entries or repeatedly failing to make essential entries on patient records, as alleged in Count II.

INITIAL DECISION

Upon a finding that a licensee has engaged in unprofessional conduct, the appropriate hearings panel must determine the extent of discipline to be imposed. Such discipline may include a letter of admonition, private or public censure, or suspension or revocation of a license to practice medicine. Section 12-36-118(5)(g)(III), C.R.S. (1991). The Inquiry Panel seeks revocation of Respondent's license in light of what it asserts is the egregious nature of Respondent's conduct in this case and his poor prospects for meaningful change. Respondent seeks probation under strict terms and conditions, asserting his conduct constituted an isolated lapse and that the public can be protected in the future by the elaborate probationary scheme he has proposed.

Respondent has been found to have engaged in substandard and grossly negligent medical practice in violation of Section 12-36-117(1)(p) in relation to his care and treatment of R.L.[14/] The nature of these violations is extremely broad, covering virtually every aspect of Respondent's care of the patient. Respondent has been found to have been deficient in his pre-surgery check of anesthesia equipment, as well as his overall preparedness, observations, vigilance and judgment during surgery. In addition, certain of Respondent's actions during the resuscitation have been found wanting and his charting has been found to be both inadequate and falsified. Specifically, Respondent failed to calibrate the anesthesia machine's oxygen analyzer; failed to employ a stethoscope to check the patient's breath sounds after intubation; failed to monitor R.L. properly during surgery, including failure to monitor temperature, failure to use a stethoscope throughout surgery to monitor breath sounds and insure proper ET tube placement after the inadvertent airway disconnect, and failure adequately to monitor ET CO_2. In addition, Respondent failed to adequately respond to evidence of R.L.'s developing crisis during surgery as evidenced by an accelerated respiratory rate, accelerated heart rate, evidence of irregularities in the patient's heart beat and elevated ET CO_2 levels. Also, at the time the COR was called, Respondent failed to take immediate steps to ascertain the adequacy of the patient's airway and breathing and failed to produce a stethoscope on request. Respondent also failed to remain awake and otherwise alert and vigilant at certain times during the surgery. Finally, Respondent's charting was inaccurate and inadequate in numerous respects and in certain cases was also falsified.

The proved violations in this matter involve extremely serious lapses in vigilance, care, judgment and treatment decisions. Respondent showed a lack of appreciation of his responsibilities to the patient; a lack of attention to and recognition of the medical issues in the

case; and a lack of concern as well as willful disregard for his obligations with respect to documentation.

Furthermore, the consequences of Respondent's actions could not have been more dire. Respondent's lack of vigilance in all likelihood directly resulted in R.L.'s death. Early detection of MH, if that was the genesis of R.L.'s crisis, would have meant a 90% survival rate. If, instead, R.L. was suffering from a compromised airway, there is no reason to believe early recognition would not have resolved the problem completely.

In mitigation, Respondent claims that R.L.'s cause of death was MH rather than prolonged undetected compromised airway. He thus acknowledges a failure to timely interpret MH signs and symptoms which he admits constituted substandard care, but denies that he failed to recognize and treat a respiratory crisis since, according to Respondent, none existed. Respondent also points to his ongoing psychiatric treatment aimed at continuing to address his depression and also addressing his longstanding personal interaction and communication style difficulties, as well as his proposed detailed probation plan, as factors which will positively impact on his future medical practice and enable the Board to insure that he is practicing medicine with skill and safety.

In aggravation the Panel asserts that Respondent's conduct in the case of R.L. and in other charged situations[15], as well as his personality disorder, establish a pattern of lack of vigilance and an attitude and pattern of communication and interaction with other professionals which indicates Respondent is not an appropriate candidate for probation. The Panel asserts Respondent's historical patterns, recent behavior and current diagnosis indicate Respondent's past unsafe practice is unlikely to change.

The Administrative Law Judge concludes that the proved charges in this matter are extremely serious, indicating a disturbing lack of vigilance, care and judgment on Respondent's part as well as a disregard for his obligations with respect to accurate and truthful charting. This is true regardless of whether the actual cause of death in this matter was MH or prolonged respiratory compromise combined with exogenous heating. In either event, Respondent's substandard actions included conduct which fell grossly below acceptable standards of medical practice, which covered multiple aspects of his care of R.L., and which likely resulted in R.L.'s death. Such actions clearly merit imposition of substantial discipline. Furthermore, Respondent's other proved statutory violations[16] along with his history of communication and personal interaction difficulties related to those violations indicate that despite Respondent's current therapy, Respondent is not likely to make meaningful changes in his behavior and is not an appropriate candidate for probation. Taken as a whole, Respondent's statutory violations in combination with his behavioral difficulties indicate he presents a serious risk for future unsafe medical practice. The Administrative Law Judge determines in light of these factors that the only disposition of this matter adequate to serve the public protection purposes of the MPA, Section 12-36-102, C.R.S., is license revocation.

It is therefore the recommended Initial Decision of the Administrative Law Judge that Respondent's license to practice medicine in the State of Colorado be revoked.

DATED AT: Denver, Colorado
May 17, 1994

Judith F. Schulman

JUDITH F. SCHULMAN
Administrative Law Judge

FOOTNOTES

1/ The Nihon-Codon machine continuously monitors patient heart rate and creates a hard copy readout. Following the patient's death, Respondent attempted to obtain this hard copy from the machine itself but was unable to do so. The hard copy was subsequently obtained by hospital personnel and was available at hearing.

2/ Although in his deposition Respondent testified that his charted pulse values came from the Nihon-Codon, at hearing Respondent asserted that the pulse values in fact came from the pulse oximeter. (No hard copy of the pulse oximeter readings was available at hearing and the Administrative Law Judge infers that none exists.) The Administrative Law Judge is somewhat skeptical with respect to Respondent's last minute change of heart as to the source of the charted pulse values. In any event, however, there was no persuasive evidence which would explain why reliance on the pulse oximeter would result in readings as divergent from the Nihon-Codon readings as those recorded by Respondent. In fact, the persuasive testimony indicated that heart rate/pulse readings from the Nihon-Codon and the pulse oximeter should be essentially identical. Therefore, Respondent failed to establish any reasonable explanation for the demonstrated divergence between his charting and the Nihon-Codon values and the Administrative Law Judge finds such diversion amounted to substandard charting inaccuracies.

3/ These heart rate figures are derived from the Nihon-Codon hard copy rather than Respondent's chart which the Administrative Law Judge has found to be inaccurate. However, even according to Respondent's own charting the patient's heart rate had increased to 94 beats per minute by 10:00 a.m., representing substantially more than a 20% increase over the baseline of approximately 68 beats per minute established according to Respondent's chart during the initial one and one-half hours of surgery.

4/ Since the patient's anesthesia was set at a relatively high level (apparently 2% halothane concentration although the exact concentration is uncertain since there is no chart entry and Respondent has made inconsistent pronouncements on this subject), it would not be likely that the patient's increasing heart rate was the result of inadequate anesthesia. Nevertheless, it was still appropriate as a first step in determining the cause of the heart rate increase to do a five minute test with more anesthesia.

5/ The record does not reflect the ET CO_2 level at this time since Respondent did not contemporaneously chart any ET CO_2 values after 9:30 a.m. However, Respondent did testify the ET CO_2 values continued to rise steadily after 9:30 a.m.

6/ The record does not reflect any specific respiratory rates prior to 10:30 a.m.; Respondent did not provide this information in testimony and did not chart any respiratory rates.

7/ The surgeon, who performed much of the surgery while looking through a microscope, was unaware of what actions, if any, Respondent took to deal with the patient's accelerated respirations.

8/ The Administrative Law Judge recognizes that complex issues are raised in conjunction with any definitive determination of the patient's actual ET CO_2 value at 10:30 and/or 10:45 a.m., including determinations of: 1) whether the PCO_2 value of 200 is itself fully accurate since the reading is apparently beyond the upper limit of complete accuracy of the testing machinery; 2) whether the first blood draw during the COR was arterial or venous; 3) whether the blood was drawn at 11:07 a.m. as charted or perhaps as much as five minutes later than that, consistent with certain other evidence presented in the case; 4) whether Respondent was assisting the patient's respirations beginning at 10:40-10:45 a.m.; and 5) whether any readings from the mass spectrometer were artificially low after 10:30 a.m. as a result of the patient breathing around the ET tube. However, a determination of the patient's actual ET CO_2 values at 10:30-10:45 a.m. and just prior to the COR is not critical to the Administrative Law Judge's resolution of the case and the Administrative Law Judge therefore does not reach this issue.

9/ This determination is based on extrapolations by the expert witnesses based on the known speed at which CO_2 levels rise in arterial blood in the total absence of any breathing (apnea). In the face of total apnea, it would take approximately 20 minutes to get from an PCO_2 of 50 (normal reading in the presence of halothane) to a reading of 200. The additional time is added because there clearly was some breathing occurring in the period prior to the COR (the patient had an oxygen saturation of 97%), although ventilation was markedly decreased. The time span necessary to reach a PCO_2 reading of 200 is thus increased.

10/ A personality disorder involves personality traits which become so inflexible and maladaptive as to cause significant functional impairment, including interference with an individual's interaction with others.

11/ Other charged statutory violations are discussed in Appendix A which is sealed consistent with the prior order of the Administrative Law Judge. *See* page 1.

12/ Respondent asserts that as a matter of fact he believes he did use a stethoscope to check R.L.'s breath sounds, but argues that whether or not he did so is immaterial because the applicable standard of care did not require him to do so. The Administrative Law Judge has found Respondent did not check for breath sounds with a stethoscope after the intubation and therefore must address the standard of care issue.

13/ Further, even if Respondent had established, which he did not, that his actions were consistent with the practice of a majority of anesthesiologists and prevailing standards of care, such evidence might not be considered conclusive proof of due care, particularly

in light of the minimal effort required to take the precautions in question; the lack of risk to the patient in taking such precautions; and the potential benefit to be derived from taking these actions. *See, Quintana v. United Blood Services*, 827 P.2d 509 (Colo. 1992) (in a professional negligence case, it is permissible to offer expert opinions that the standard of care adopted by defendant's school of practice is unreasonably deficient by not incorporating readily available practice and procedures substantially more protective against the harm caused to the plaintiff than the standard of care adopted by defendant's school of practice); *Helling v. Carey*, 519 P.2d 981 (Wash. 1974); *The T.J. Hooper*, 60 F.2d 737 (2d Cir.) cert. denied 287 U.S. 662 (1932); *Texas & Pacific Ry v. Behymer*, 189 U.S. 468 (1903). *See also Melville v. Southward*, 791 P.2d 383 (Colo. 1990) (standard of care in a medical malpractice case is measured by the standard of the reasonably careful physician).

14/ *See* Footnote 11.

15/ *See* Footnote 11.

16/ *See* Footnote 11.

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